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Save the Children

MATERNAL, INFANT and YOUNG CHILD NUTRITION (MIYCN)

TRAINING MANUAL FOR HEALTH WORKERS

PARTICIPANT MANUAL

December 2012

ENGINE: Empowering New Generations to Improve Nutrition and Economic opportunities

A program under the Global Health Initiative and Feed the Future Initiative

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Acronyms

AIDS	Acquired immune deficiency syndrome
ANC	Antenatal care
ARI	Acute respiratory infection
AFASS	Affordable, feasible, acceptable, sustainable and safe
AROM	Artificial rupture of membranes
ARVs	Antiretroviral drugs
BF	Breastfeeding
CC	Counseling cards
CMAM	Community-based management of acute malnutrition
ENGINE	Empowering New Generations to Improve Nutrition and Economic opportunities
EBF	Exclusive breastfeeding
GMP	Growth monitoring and promotion
HIV	Human immunodeficiency virus
IDA	Iron deficiency anemia
IDD	Iodine deficiency disorder
IQ	Intelligent quotient
ITNs	Insecticide-treated nets
IYCF	Infant and young child feeding
IYCN	Infant and young child nutrition
MIYCN	Maternal, infant and young child nutrition
MTCT	Mother-to-child transmission
NNP	National Nutrition Program
NNS	National Nutrition Strategy
PMTCT	Prevention of mother-to-child transmission
RUTF	Ready to use therapeutic foods
SFP	Supplementary feeding program
STI	Sexually transmitted infection
USAID	United States Agency for International Development
UNICEF	United Nations Children's Fund
VAD	Vitamin A deficiency
WHO	World Health Organization

Session 1: About This Training Manual

This manual is a resource designed to equip health workers with the knowledge and skills to provide quality nutrition services for optimal feeding of women, adolescent girls, infants and young children at the facility level. The contents of this training manual are adapted from a variety of materials developed by UNICEF, WHO, USAID's IYCN project and from the Gates Foundation's Alive & Thrive (A&T) "Complementary Feeding Training Manual" developed for Ethiopia.

Target group

Although this training manual is designed for health care workers working at health facilities, particularly health centers, supervisors, managers and university instructors are also encouraged to attend the training so that they become familiar with the training content and skills, and thus better able to support and mentor the health workers on an ongoing basis.

Specific training objectives

This manual was developed using methodologies and technical content appropriate for use by health workers. The content focuses on breastfeeding, complementary feeding, feeding sick infants and young children, infant feeding in the context of HIV, women's and adolescent nutrition, as well as counseling, coaching and mentoring skills. By the end of the training, participants will be able to:

- Explain why maternal, adolescent, infant and young child nutrition practices matter.
- Demonstrate appropriate use of counseling skills (listening and learning; building confidence and giving support [practical help]).
- Describe recommended feeding practices through the first 2 years of life; demonstrate use of related counseling discussion points and technical material.
- Describe how to breastfeed effectively and identify ways to prevent and resolve common breastfeeding difficulties.
- Describe various aspects of appropriate complementary feeding during the period from 6 to 24 months and counsel caregivers according to their situation.
- Describe practices for feeding the sick child or recovering from illness and provide counseling to caregivers.
- Describe basic information on infant feeding in the context of HIV.
- Counsel pregnant women and mothers on appropriate nutrition practices during pregnancy and breastfeeding.
- Describe supervision and mentoring skills.

Session 2: Why Nutrition Matters

Introduction

Malnutrition is one of the main health problems facing children and women in Ethiopia. The country faces the four major forms of malnutrition: acute and chronic malnutrition, iron deficiency anemia (IDA), vitamin A deficiency (VAD) and iodine deficiency disorder (IDD). The 2011 DHS has shown that 44 percent and 10 percent of children under 5 were stunted and wasted respectively. The weight for age indicator shows that 29 percent of children under 5 were underweight. Malnutrition is also prevalent in women with 27 percent chronically malnourished (BMI less than 18.5).

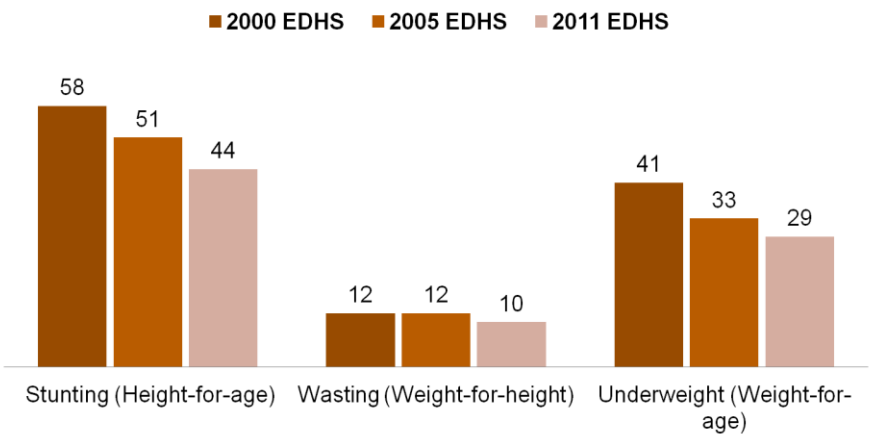
Learning objectives

1. To provide an overview of the status of malnutrition and infant and young child feeding practices in Ethiopia.
2. To focus on the first 1,000 days offering a window of opportunity for good nutrition and to understand the consequences of undernutriton at this critical period of growth.

Table 1: Status of malnutrition in Ethiopia

Indicator	Status	Reference
Infants under 6 months who are fed using a bottle with a nipple	16%	DHS 2011
Infants under 6 months who are exclusively breastfed	52% (half are not exclusively breastfed)	»
Infants 6 to 9 months who are given complementary foods (CF)	51% (half are not given CF at the right time)	»
Malnutrition	29% underweight 44% stunting 10% wasting	»
Anemia in women	17%	»
Anemia during pregnancy	22%	»
Maternal undernutrition	27%	»

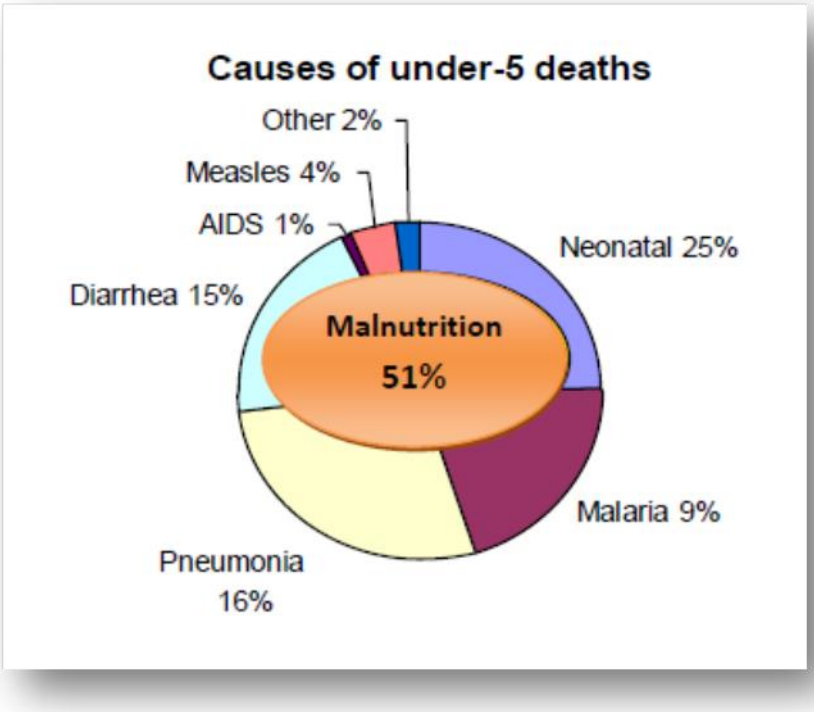
This graph shows the summary of data of the DHS



When comparing the 2000, 2005 and 2011 DHS data, the results show improvement in the status of malnutrition in children. However, more work is still needed to overcome malnutrition problems.

Nutrition is a human right. It has human and economic cost and negative functional consequences such as:

- Increased illness and mortality
- Loss of intelligence
- Reduced productivity



Data source health and health related indicators FMOH 2011

Key information

Malnutrition and infant mortality and morbidity

Some of the causes of infant mortality in Ethiopia are the following:

- Neonatal 25%
- Pneumonia 16%
- Diarrhea 15%
- Malaria 9%
- Measles 4%
- AIDS 1%
- Other 2%

More than half of these deaths can be averted by preventing malnutrition. Suboptimal breastfeeding accounts for 24% of infant mortality and vitamin A deficiency causes 17% of infant deaths.

Malnutrition and education

- Undernutrition can have a profound impact on infant development from conception through the second birthday, the 1,000 day window. Irreversible damage to the physical, mental and social development of the child can occur during this period. Damage due to anemia, iodine deficiency and chronic malnutrition can only partially be reversed later in life. Providing health, nutrition and psychosocial stimulation early in a child's life can prevent malnutrition and its impact on learning. Early childhood is the most cost-effective period for investment in education and integrated attention to the young child is critical.

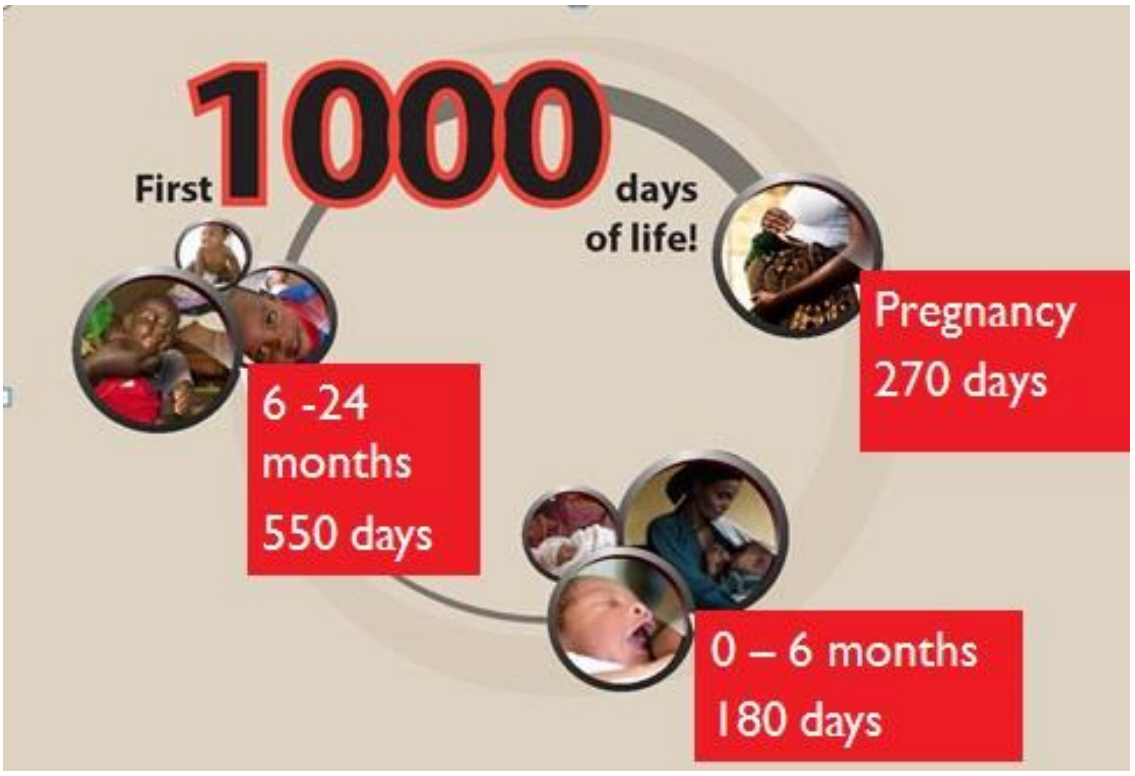
- A child who is undernourished is at risk of suffering from cognitive and phusical impairment which impacts the quality of life as a child and an adult with in the society.stunted children are more likely to repeat grads in school or even drop out. The consequences of undernutrition will be: reduced intellectual development; reduced school performance; reduced economic productivity; and reduced IQ. Iron deficiency anemia can lower IQ by 9 points, mild iodine deficiency can lower IQ by 10 points, severe stunting by 5-10 points and low birth weight by 5 points. The cost of hunger analysis in Ethiopia assessed by EHNRI 2013 Ethiopia has lost 93 million birr due to grade repetition which is equivalent to 0.03% of the GDP.

Malnutrition and economic development

According to the Cost of Hunger Ethiopia the country lost 1.822 billlion birr due to low birth weight and increased mortality. Loss due to grade repetation in public and privet schools costs the education sector 93 million. Productivity loss due to manual and none manual activities and lower productivity due to mortality costed 53.55 billion. The overall productivity loss due to the impact on health, education and productivity loss due to mortality casted the country 55.5 billion birr. 16% of the country's GDP(COH 2013 EHNRI).

1,000 DAY WINDOW OF OPPORTUNITY

A focus on nutrition during pregnancy and up to the age of 2 years is proven to yield a high return on investment. Leading economists, including Nobel laureates, have declared that five of the top ten most cost effective solutions for development focus on improving nutrition. The impact of poor maternal and child nutrition is lasting with consequences reaching beyond health, having the potential to reduce the economic output of countries by 2-3 percent annually.(World Bank,2010).



Why focus on the first 10000 days

1. Brain development

During the first 1000 days the baby needs plenty of nourishment, a healthy and secure environment and the right sort of stimulation the brain to to grow fully.Baby's brain is only 15% formed at birth. The remaining 85% is formed in the first 1000 days of life.

2. 'Hard-wiring' the brain for social competence

During the first 1000 days a baby's brain grows from 300grams to 1.2kg. For that to occur it needs the right stimulation. The baby also needs a loving, secure relationship in which to develop a strong emotional attachment and learn to trust and love.

3.**Learning physical skills**

During the first 1000 days of life babies learn basic physical skills and confidence. The right environment, lovingly supportive and stimulating. The child then grows into maturity both confident in their physical abilities and also with an aptitide for picking up new physical skills.

4: Learning to talk

During the first 1000 days a baby needs adults to talk to them constantly. It is only by hearing people talking to each other and by being talked to that a baby discovers that people communicate with each other in this way.

5: Learning right and wrong

During the first 1000 days the groundwork is laid for learning the difference between right and wrong. This process continues right through childhood and adolescence and into adulthood by when the child will be a mature caring person of sound moral judgment.

6: Health

During the first 1000 days a child's health is particularly vulnerable. Warm, dry housing, plenty of nourishing food, protection from contagious disease and access to primary health care are essential..

7: Economic

.Effective public investment in the first two years of a child's life is one of the best investments any government can make. Not only does it protect the child from the damaging effects of poverty but it also produces proven good returns in later years.

First 1,000 days

Learning objective: To focus on the first 1,000 days offering a window of opportunity for good nutrition and to understand the consequences of undernutrition during this critical period of growth.

Malnourished mothers often have malnourished children. Poor maternal and child nutrition during the 1,000 day window of opportunity inhibits both physical and intellectual development. Malnourishment contributes to diminished academic achievement during childhood, which translates into reduced earning potential as adults. The effects of poor early nutrition last long into adulthood, as individuals are less able to improve their own futures and to contribute to better lives for their children, families and communities.

Key information

- Children, particularly those younger than 2, are at special risk of hunger.
- The consequences of malnutrition during this critical window of development are long-term and irreversible.
- Poor fetal growth and persistent undernutrition early in life causes permanent damage, including diminished intellectual capacity,
- Impaired immune function and reduced height.
- These problems lead to lower achievement in school and lower productivity on the job.
- To tackle this problems working on nutrition at this age; from pregnancy to the age of 24 months are crucial.

Session 3: Interpersonal Communication

Introduction

Counseling is a way of working with people in which you understand how they feel and help them to decide what they think is best to do in their situation. In this session, we will discuss mothers who are feeding young children and how they feel. Counseling mothers on feeding their infants is not the only situation in which counseling is useful. Counseling skills are useful when you talk to patients or clients in other situations. You may also find them helpful with your family, friends or your colleagues at work. Practice some of the techniques with them − you may find the result surprising and helpful.

Learning objectives

1. To list and explain the basic listening and learning skills used in counseling.
2. Describe how to counsel mother/father/caregiver.

Skill 1: Use helpful, nonverbal communication

Nonverbal communication means showing your attitude through your posture, your expression, everything except through speaking. Helpful nonverbal communication makes a mother feel that you are interested in her, so it helps her to talk to you.

HELPFUL NONVERBAL COMMUNICATION

- **Keep your head level**
- **Pay attention**
- **Remove barriers**
- **Take time**
- **Touch appropriately**

Demonstration 3.A: Nonverbal communication

With each demonstration say **exactly the same** words, and use the same tone of voice, for example: *"Good morning, Almaz. How is feeding going for you and your baby?"*

1. **Posture:**
   Helps: Sit so that your head is level with hers.
   Hinders: Stand with your head higher than hers.

2. **Eye contact:**

Helps: Look at her and pay attention as she speaks.
Hinders: Look away at something else or look down at your notes.

3. **Physical barriers:**
   Helps: Remove the table and your notes.
   Hinders: Sit behind a table or write notes while you talk.

4. **Taking time:**
   Helps: Make her feel that you have time. Sit down and greet her without hurrying. Continue smiling at her, watching her breastfeed and wait for her to answer.
   Hinders: Act rushed. Greet her quickly; show signs of impatience; look at your watch.

5. **Touch:**
   Helps: Touch the mother appropriately.
   Hinders: Touch her in an inappropriate way.

(Note: If you cannot demonstrate an inappropriate touch, simply demonstrate not touching.)

Discuss appropriate touch in this community

- What kinds of touch are appropriate and inappropriate in this situation for this community?
- Does touch make a mother feel that you care about her?
- If it is not appropriate for a man to touch a woman, is it appropriate for him to touch the baby?

Skill 2: Ask open questions

Open questions are very helpful. To answer them, a mother must give you some information. Open questions usually start with 'How? What? When? Where? Why?' For example: "How are you feeding your baby?"

Closed questions tend to be less helpful. They often tell a mother the answer that you expect, and she can answer them with a 'Yes' or 'No'. They usually start with words like 'Are you?', 'Did he?', 'Has he?', 'Does she?' For example: "Did you breastfeed your last baby?" If a mother says "Yes" to this question; you still do not know if she breastfed exclusively, or if she also gave some supplemental feeds. To start a conversation, general open questions are more helpful. For example: "Tell me about your baby?" To continue a conversation, a more specific open question may be helpful. For example: "How old is your baby now?" Sometimes it is useful to ask a closed question, to confirm a fact. For example: "Are you giving him any other food or drink?" If she says "Yes", you can follow up with an open question to learn more. For example: "What made you decide to do that?"

Demonstration 3.B: Closed questions to which she can answer 'yes' or 'no'

Health worker: –Good morning, (name). I am (name), the health worker. Is (child's name) well?
Mother: –Yes thank you.
Health worker: –Are you breastfeeding him?
Mother: –Yes.
Health worker: –Are you having any difficulties?
Mother: –No.
Health worker: –Is he breastfeeding very often?
Mother: –Yes.

Demonstration 3.C: Open questions

Health worker: –Good morning, (name). I am (name), the health worker. How is (child's name)?
Mother: –He is well and he is very hungry.
Health worker: –Tell me, how are you feeding him?
Mother: –He is breastfeeding. I only have to give him one bottle feeding in the evening.
Health worker: –What made you decide to do that?
Mother: –He wants to eat too much at that time, so I thought that my milk is not enough.

Demonstration 3.D: Starting and continuing a conversation

Health worker: –Good morning, (name).How are you and (child's name) getting on?
Mother: –Oh, we are both doing well, thank you.
Health worker: –How old is (child's name) now?
Mother: –He is 2 days old today.
Health worker: –How are you feeding him?
Mother: –He is breast feeding and drinking water.
Health worker: –What made you decide to give him water?
Mother: –There is no milk in my breasts and he doesn't want to suck.

Exercise 3.a: Asking open questions

'Closed' questions	'Open' questions
Example: Do you breastfeed your baby?	**Example: How are you feeding your baby?**
1. Does your baby sleep with you?	Where does your baby sleep?
2. Are you often away from your baby?	How much time do you spend away from your baby?
3. Does Amina eat porridge?	What types of food does Amina like to eat?
4. Do you give fruit to your child often?	How often does your child eat fruit?

Skill 3: Use responses and gestures that show interest

Another way to encourage a mother to talk is to use gestures such as nodding and smiling, and simple responses such as "Mmm", or "Aha". They show a mother that you are interested in her.

Demonstration 3.E: Using responses and gestures that show interest

Health worker: –Good morning, (name).How is (child's name) now that he has started solids?
Mother: –Good morning. He's fine, I think.
Health worker: –Mmm. (nods, smiles)
Mother: –Well, I was a bit worried the other day because he vomited.
Health worker: –Oh dear! (raises eye brows, looks interested)
Mother: –I wondered if it was something in the stew that I gave him.
Health worker: –Aha! (nods sympathetically)

Skill 4: Reflect back what the mother says

Reflecting back means repeating back what a mother has said to you to show that you have heard her correctly and to encourage her to say more. Try to say it in a slightly different way. For example, if a mother says: "I don't know what to give my child, she refuses everything. You could say: "Your child is refusing all the food you offer her?"

Demonstration 3.F: Continuing to ask for facts

Health worker: –Good morning, (name).How are you and (child's name) today? *Mother:* –He wants to feed too much –he is on my breast all the time!
Health worker: -About how often would you say?
Mother: -About every half an hour.
Health worker: –Does he wants to suck at night too?
Mother: –Yes.

Demonstration 3.G: Repeating back

Health worker: –Good morning, (name).How are you and (child's name) today? *Mother:* –He wants to feed too much—he is on my breast all the time! *Health worker:* –(Child's name) is feeding very often?
Mother: –Yes. This week he is so hungry. I think that my milk is drying up.
Health worker: –He seems hungrier this week?
Mother: –Yes, and my sister is telling me that I should give him the bottle as well.
Health worker: –Your sister says that he needs something more?
Mother: –Yes. Which formula is best?

Exercise 3.b: Repeating back what a mother says

Statements to 'repeat back':

1. Mekdes does not like to eat thick porridge.
2. She doesn't seem to want to suckle from me.
3. I tried feeding her from a bottle, but she spat it out.

Skill 5: Empathize: show that you understand how she feels

Empathy or empathizing means showing that you understand how a person feels. For example, if a mother says: "My baby wants to feed very often and it makes me feel so tired" you could say: "You are feeling very tired all the time then?" This shows that you understand that she feels tired, so you are empathizing. If you respond with a factual question, for example, "How often is he feeding? What else do you give him?" you are not empathizing.

Demonstration 3.H: Sympathy

Health worker: 'Good morning, (name).How are you and (child's name) today?
Mother: '(Child's name) is not feeding well. I am worried he is ill.
Health worker: 'I understand how you feel. When my child was ill, I was so worried. I know exactly how you feel.
Mother: 'What was wrong with your child?

Demonstration 3.I: Empathy

Health worker: Good morning, (name).How are you and (child's name) today?
Mother: 'He is not feeding well. I am worried he is ill.
Health worker: 'You are worried about him?
Mother: 'Yes, some of the other children in the village are ill and I am frightened he may have the same illness.
Health worker: 'It must be very frightening for you.

Demonstration 3.J: Asking facts

Health worker: 'Good morning, (name).How are you and (child's name) today?
Mother: 'He is refusing to breast feed since he started eating porridge and other foods last week. He just pulls away from me and doesn't want me!
Health worker: 'How old is (child's name) now?
Mother: 'He is seven months old.
Health worker: 'And how much porridge does he eat during the day?

Skill 6: Avoid words that sound judging

Judging words are words like: right, wrong, well, badly, good, enough, properly. If you use these words when you ask questions, you may make a mother feel that she is wrong or that there is something wrong with her baby. However, sometimes you need to use the 'good' judging words to build a mother's confidence.

Demonstration 3.K: Using judging words

Health worker: 'Good morning. Is (child's name) breastfeeding **normally**?
Mother: "Well, I think so.
Health worker: 'Do you think that you have **enough** breast milk for him?
Mother: 'I don't know…I hope so, but may be not... (She looks worried.) *Health worker:* 'Has he gained weight **well** this month?
Mother: 'Don't know….
Health worker: 'May I see his growth chart?

Demonstration 3.L: Avoiding judging words

Health worker: 'Good morning. How is breastfeeding going for you and (child's name)?
Mother: 'It's going very well. I haven't needed to give him anything else.
Health worker: 'How is his weight? Can I see his growth chart?
Mother: 'Nurse said that he gained more than half a kilo this month. I was pleased.
Health worker: 'He is obviously getting all the breast milk that he needs.‖

JUDGING WORDS

Judging Words			
Well	**Normal**	**Enough**	**Problem**
Good	Correct	Adequate	Fail
Bad	Proper	Inadequate	Failure
Badly	Right	Satisfied	Succeed
	Wrong	Plenty	Success
		Sufficient	

USING AND AVOIDING JUDGING WORDS			
English	**Local language**	**Judging Questions**	**Non-judging Questions**
Well		Does he suck well?	How is he sucking?
Normal		Are his stools normal?	What are his stools like?
Enough		Is he gaining enough weight?	How is your baby growing?
Problem		Do you have any problems breastfeeding?	How is breastfeeding going for you?

1.1 How to counsel mother/father/caregiver

In the following section we are going to learn how to counsel mothers/fathers/caregivers by using the three steps of counseling process.

Describe Three-Step Counseling process (access, analyze, and act)

- The Three-Step Counseling process involves:
  - *Assess* age-appropriate feeding and condition of mother/father/care giver and child: ask, listen, and observe.
  - *Analyze* feeding difficulty: identify difficulty, and if there is more than one, prioritize.
  - *Act* discuss and suggest some relevant information, agree on a doable option that mother/father/caregiver can try.
- The purpose of the process is to provide information and support on infant and young child feeding to the mother/father/caregiver.

Step 1: Assess

- Greet the mother/father/caregiver and ask questions that encourage her/him to talk, using 'listening and learning' and 'building confidence and giving support' skills.
- Complete *Resource 3*: Observation checklist for infant and young child feeding assessment of mother/child pair, by asking the following questions:

a) What is your name and your child's name?

b) Observe the general condition of the mother/father/caregiver.

c) What is the age of your child?

d) Has your child been sick recently? If currently sick, refer mother to health facility.

e) In areas where child growth cards exist, ask mother/father/caregiver if you can check child's growth card. Is growth curve increasing? Is it decreasing? Is it leveling off? Does the mother know how her child is growing?

f) In areas where there are no child growth cards, ask mother/father/caregiver how he or she thinks the child is growing?

g) Ask about the child's usual feeding intake:

Ask about breast feeding:

- About how many times per day do you breast feed your baby?
- How is breast feeding going for you? *Possible difficulties?*
- *Observe* mother's and baby's general condition.
- *Observe* baby's position and attachment.

Ask about complementary foods:

- Is your child getting anything else to eat? *What type/kinds?*
- Ask about the frequency, amount, and consistency of the food the child is getting.

Ask about other milk:

- Is your child drinking other milk?
- Ask about the frequency and amount of milk.
- If breast feeding, why do you think the baby needs additional milk?

Ask about other liquids:– Is your child drinking other liquids? *What kinds?*

- Ask about the frequency and amount of liquid.

h) Does your child use a cup? (If mother says 'no' then ask, 'What does your child use to drink from?

i) Who assists your child with eating?

j) Are there other challenges the mother faces in feeding the child?

Step 2: Analyze

- Is feeding age-appropriate? Identify feeding difficulty (if any).
- If there is more than one difficulty, prioritize difficulties.
- Answer the mother's questions (if any).

Step 3: Act

- Depending on the age of the baby and your analysis (above), select a small amount of information relevant to the mother's situation. If there are no difficulties, praise the mother for carrying out the recommended breastfeeding and complementary feeding practices.

- Praise the mother.
- Present options/small do-able actions (time-bound) and help the mother select one that she can try to overcome the difficulty.
- Share and discuss with the mother/father/care giver any appropriate counseling cards.
- Ask the mother to repeat the agreed-upon new behavior to check her understanding.
- Thank the mother for her time

Use Resource 3: Observation checklist

Infant and young child feeding assessment of mother/child pair to demonstrate the Three-Step Counseling process.

1. ***Step 1: Assess***
   - Greet mother and introduce yourself.
   - Allow mother to introduce herself and her baby.
   - Use listening and learning' and 'building confidence and giving support' skills.
   - Listen to Almaz's concerns, and observe Kebede and Almaz.
   - Accept what Almaz is doing without disagreeing or agreeing, and praise Almaz for one good behavior.

2. ***Step 2: Analyze***

   Facilitator acting as counselor notes that:
   - Almaz is waiting until Kebede cries before breast feeding him—a 'late sign' of hunger.
   - Almaz is worried she does not have enough breast milk.
   - Almaz is not feeding Kebede age-appropriate complementary foods.

3. ***Step 3: Act***
   - Praise Almaz for breastfeeding.
   - Ask Almaz about breastfeeding frequency and whether she is breastfeeding whenever Kebede wants and for as long as he wants, both day and night. Does Kebede come off the breast himself? Is Kebede fed on demand? (Age-appropriate recommended breastfeeding practices)
   - Suggest that Almaz breastfeed Kebede whenever he shows interest in feeding (before he starts to cry). Talk with Almaz about the characteristics of complementary feeding.
   - Present small do-able actions (time-bound) to overcome the difficulty of inadequate complementary feeding.
   - Help Almaz select an action that she can try(e.g., breastfeed more frequently both day and night, thicken the porridge, add family foods during this week).
   - Ask Almaz to repeat verbally the agreed-upon action.
   - Tell Almaz that a counselor will follow up with her at her next weekly visit.
   - Suggest where Almaz can find support (attend educational talk, infant and young child feeding support group, supplementary feeding program, or community volunteer).
   - Thank Almaz for her time.

Key information

Building confidence and giving support skills

1. Accept what a mother/father/caregiver thinks and feels. To establish confidence, let the mother/father/care giver talk through her/his concerns before correcting information. Sometimes a mother feels very upset about something that you know is not a serious problem. If you say something like "Don't worry, there is nothing to worry about!" you make her feel like she is wrong to feel the way she does and you do not understand her, which reduces her confidence. If you accept that she is upset, it makes her feel that it is alright to feel the way she does which strengthens her confidence. Empathizing is one useful way to show acceptance of how a mother feels.

2. Recognize and praise what a mother/father/caregiver and baby are doing correctly.
   As health workers, we are trained to look for problems. We see only what we think people are doing wrong and we try to correct them. As counselors, we must learn to look for and recognize what mothers and babies do right and offer praise or show approval for the good practices.

Praising good practices has these benefits:

- It builds a mother's confidence.
- It encourages her to continue those good practices.
- It makes it easier for her to accept suggestions later.

1. Give practical help.

Sometimes practical help is better than saying anything, such as:

- when a mother feels tired or dirty or uncomfortable
- when she is hungry or thirsty
- when she has had a lot of information already
- when she has a clear practical problem

Some ways to give practical help are these:

- help to make her clean and comfortable
- give her a drink or something to eat
- hold the baby while she gets comfortable or washes or goes to the toilet

Practical help includes showing caregivers how to prepare foods rather than just giving them a list of instructions. It also includes offering help with breastfeeding such as helping a mother with positioning and attaching, expressing breast milk, relieving engorgement or preparing complementary foods.

2. Give a small amount of relevant information.

When you give a mother information, remember these points:

- Tell her things that she can do today, not in a few weeks.
- Explain the reason for a difficulty to help her understand what is happening.
- Try to give only one or two pieces of information at a time, especially if she is tired and has already received a lot of advice.
- Wait until you have built her confidence by accepting what she says and praising what she and her baby do right. You do not need to give new information or to correct a mistaken idea immediately.
- Give information in a positive way so that it does not sound critical. This is especially important if you want to correct a mistaken idea.

3. Use simple language.

Use simple, familiar terms to explain things to mothers. Remember that most people do not understand the technical terms that health workers use.

4. Use the appropriate counseling card or cards.

Based on the thematic area you are covering, use the proper card(s).

5. Make one or two suggestions, not commands.

Be careful not to force or command a mother to do something. This does not help her confidence. When you counsel a mother, suggest what she could do differently. She can then decide if she will try it or not which leaves her feeling in control and helps boost her confidence.

Practice Three-Step Counseling process at classroom practical session

Case studies to practice Three-Step Counseling

Case study 1

Read to mothers: You are Fatuma. Your son, Shukri, is 18 months old. You are breastfeeding once or twice a day. You are giving Shukri milk and millet cereal two times a day.

Step 1: Assess

- Greet Fatuma and ask questions that encourage her to talk, using' listening and learning'and 'building confidence and giving support' skills.
- Complete *Resource 3*: Observation checklist for infant and young child feeding assessment of mother/child pair.
- Observe Fatuma and Shukri's general condition.
- Listen to Fatuma's concerns and observe Shukri and Fatuma interacting.
- Accept what Fatuma is doing without disagreeing or agreeing.

Step 2: Analyze

- Fatuma is breastfeeding Shukri.
- Fatuma is giving other milk to Shukri.
- Fatuma is not following age-appropriate feeding recommendations (e.g., frequency and variety).

Step 3: Act

- Praise Fatuma about continuing breastfeeding.
- Talk with Fatuma about the characteristics of complementary feeding: frequency, amount, thickness (consistency), variety, active/responsive feeding, and hygiene.
- Present options/small do-able actions (time-bound) to overcome the difficulty of inadequate complementary foods. For example, suggest an increase in feeding frequency to four times a day; ask about the amount of cereal Shukri receives and the possibility of increasing the amount; ask about the texture (thickness/consistency) of the cereal; suggest adding other locally available family foods and help Fatuma select one or two that she believes will be possible for her to try.
- Select the information on the age-appropriate counseling cards that is most relevant to Shukri's situation and discuss it with Fatuma, such as:

Case study 2

Read to mothers: You are Abeba. Your daughter, Tirunesh, is 8 months old. You are breastfeeding Tirunesh because you know breast milk is the best food for her. You also give Tirunesh water because it is so hot. You do not think Tirunesh is old enough to eat other foods.

Step 1: Assess

- Greet Abeba and ask questions that encourage her to talk, using 'listening and learning' And 'building confidence and giving support'skills.
- Complete *Resource 3*: Observation checklist for infant and young child feeding assessment of mother/child pair.
- Observe Abeba's and Tirunesh's general condition.
- Listen to Abeba's concerns and observe Tirunesh and Abeba interacting.
- Accept what Abeba is doing without disagreeing or agreeing.

Step 2: Analyze

- Abeba is breastfeeding Tirunesh.
- Abeba is also giving water to Tirunesh
- Abeba has not started complementary foods yet.

Step 3: Act

- Praise Abeba for breastfeeding.
- Talk with Abeba about the importance of breastfeeding.
- Talk about breast milk being the best source of liquids for Tirunesh.
- Discuss the risks of contaminated water.
- Talk with Abeba about beginning complementary foods and why it is necessary for Tirunesh at this age.
- Talk with Abeba about the characteristics of complementary feeding: frequency, amount, thickness (consistency), variety, active/responsive feeding, and hygiene.
- Present options/small do-able actions (time-bound) and help Abeba select one or two that she can try. For example, begin with a small amount of staple foods (porridge, other local foods); add legumes, vegetables, fruits, and animal foods; increase feeding frequency of foods to three times a day; talk about appropriate texture (thickness/consistency) of porridge; assist Tirunesh during feeding times; and discuss hygienic preparation of foods.;
- Select the information on the age-appropriate counseling cards that is most relevant to Tirunesh's situation and discuss it with Abeba, such as:

Case study 3

Read to mothers: You are Rahima. You are breastfeeding Shamebo, who is 3 weeks old. You feel a lump in your breast; it is tender and red.

Step 1: Assess

- Greet Rahima and ask questions that encourage her to talk, using 'listening and learning' And 'building confidence and giving support' skills.
- Complete *Resource 3*: Observation checklist for infant and young child feeding assessment of mother/child pair.
- Observe Rahima's and Shamebo's general condition.
- Listen to Rahima's concerns and observe Shamebo and Rahima interacting.
- Accept what Rahima is doing without disagreeing or agreeing.

Step 2: Analyze

- Rahima wants to breastfeed Shamebo.
- Rahima has a lump in her breast that is tender and red (plugged duct).

Step 3: Act

- Praise Rahima for wanting to breastfeed Shamebo.
- Use pillows or rolled-up towels to help Rahima get comfortable for breastfeeding.
- Help Rahima improve Shamebo's attachment and suction on the breast.
- Give her ideas to relieve plugged ducts:
  - Do not stop breastfeeding. If the milk is not removed, the risk of abscess increases; let the baby feed as often as possible.
  - Apply warmth such as warm water or a warm cloth to the breast.
  - Hold the baby in different positions, so that the baby's tongue/chin is close to the site of the plugged duct/mastitis (the reddish area). The tongue/chin will massage the area and release the milk from that part of the breast.
- Apply gentle pressure to the breast with the hand, rolling fingers towards the nipple; then express the milk or let the baby feed every two to three hours day and night.
- Explain to Rahima the importance of exclusive breastfeeding, allowing Shamebo to release the milk by sucking, and frequent breastfeeding (day and night and as often as possible).
- Select the information on the age-appropriate counseling cards that is most relevant to Shamebo's situation and discuss it with Rahima, such as:

Summary of confidence and support giving skills

- **Accept what a mother thinks and feels**
- **Recognize and praise what a mother and baby are doing correctly**
- **Give practical help**
- **Give a small amount of relevant information**
- **Use simple language**
- **Use the appropriate counseling card or cards**
- **Make one or two suggestions, not commands**

Key information

Three-Step Counseling can be conducted in health clinics and by community-based outreach. Locations and timing include:

- At the antenatal clinic and at every contact with a pregnant woman.
- At delivery or as soon as possible thereafter.
- Within the first week of birth (days 2 or 3 and days 6 or 7).
- At two other postnatal points (weeks 4 and 6).
- At family planning sessions and at other times if mother has a difficulty.
- During the first 6 months of lactation (and up to 24 months of lactation).
- At Growth Monitoring Promotion (GMP) and immunization sessions.
- At every contact with mothers or caregivers of sick children.
- At contact points for vulnerable children, e.g., HIV-exposed or infected children.
- During community follow-up.
- Inaction-oriented group sessions.
- At infant and young child feeding support groups.
- At in-patient facilities for management of children with severe acute malnutrition, such as stabilization centers (SC), nutrition rehabilitation units, therapeutic feeding centers, and malnutrition wards.
- At community-based management of acute malnutrition (CMAM) sites or screening sessions.
- At supplementary feeding program (SFP) sites.
- During mother/father/caregiver counseling sessions.

Session 4: Adolescent and Maternal Nutrition

Introduction

Nutrition is vital to women's overall health. Pregnancy and lactation are critical times when women need additional nutrients, calories and more variety in their diet, not only for themselves, but for the health of their infant as well. Adolescent girls also need to eat a healthy diet because they are in a period of rapid growth and development that requires a variety of nutritious foods.

Learning objectives

1. Describe key nutritional practices during pregnancy and learn how to counsel a pregnant woman.
2. Learn key nutritional practices during lactation.
3. Understand the undernutrition cycle.

Key Nutritional Practices during Pregnancy and Lactation

Key nutritional practices during pregnancy

During pregnancy, women need more food, a varied diet and micronutrient supplements. Without an increase of energy and other nutrients from food, a pregnant woman's reserves will be used leaving her depleted and weakened. Inadequate weight gain during pregnancy often results in low birth weight, which increases an infant's risk of illness or death. Pregnant women also require more protein, iron, iodine, vitamin A, folate and other nutrients. Deficiencies of certain nutrients are associated with maternal complications and death, fetal and newborn death, birth defects, and decreased physical and mental potential of the child. Therefore, the key nutritional practices which need to be promoted during pregnancy are:

- Eat **one** extra meal each day. Eating more helps the baby to develop properly and strengthens the woman for delivery.
- Eat a variety of foods (cereals, legumes, animal products, fruits and vegetables) to remain healthy and strong and to help the baby grow and develop properly.
- Take iron supplements as soon as you find out you are pregnant and continue for at least 3 months after delivery.
- Take deworming tablets between the fourth and sixth month of pregnancy to protect mother and baby from infections.
- Use iodized salt to help your baby‘s brain and body develop properly.
- Visit a health center regularly to monitor your weight.
- Use mosquito nets to prevent malaria.
- Decrease work load and get plenty of rest.
- Avoid alcohol and smoking during pregnancy. Alcohol and cigarette smoking can harm the health of the fetus in the womb.
- Avoid drinking tea and coffee during meals. Tea and coffee change the way your body uses the food you eat. It is better to drink tea and coffee at least one or more hours before or after a meal.

Key nutritional practices during lactation

Women who do not get enough energy and nutrients in their diet risk maternal depletion. To prevent this, extra food must be made available to the mother. Breastfeeding also increases the mother's need for

water, so it is important that she drinks enough to satisfy her thirst. Maternal deficiencies of some micronutrients can affect the quality of breast milk. These deficiencies can be avoided if the mother improves her diet during lactation. Therefore, the key nutritional practices which need to be promoted during lactation are:

- Eat **two** extra meals each day.
- Eat a variety of foods (cereals, legumes, animal products, fruits and vegetables) to remain healthy and strong and to help the baby grow and develop properly.
- Use iodized salt to help your baby‘s brain and body develop properly.
- Avoid alcohol and smoking. Alcohol and cigarette smoking can harm the health of the breastfeeding child.
- Avoid drinking tea and coffee during meals. Tea and coffee change the way your body uses the food you eat. It is better to drink tea and coffee at least one or more hours before or after a meal.
- Visit a health center regularly for assessment and treatment of malnutrition.
- Use mosquito nets to prevent malaria.
- Decrease work load and get rest.

The Undernutrition Cycle

The cycle of poor nutrition is perpetuated across generations. Young girls who grow poorly become stunted (low height for their age) women and are more likely to give birth to low birth weight infants. If those infants are girls, they are likely to continue the cycle by being stunted in adulthood. Adolescent pregnancy heightens the risk of low birth weight and the difficulty of breaking the cycle. Good nutrition needs support during all of these stages—infancy, childhood, adolescence and adulthood—especially for girls and women. (See Figure 1 below)

Figure 1: The Undernutrition Cycle

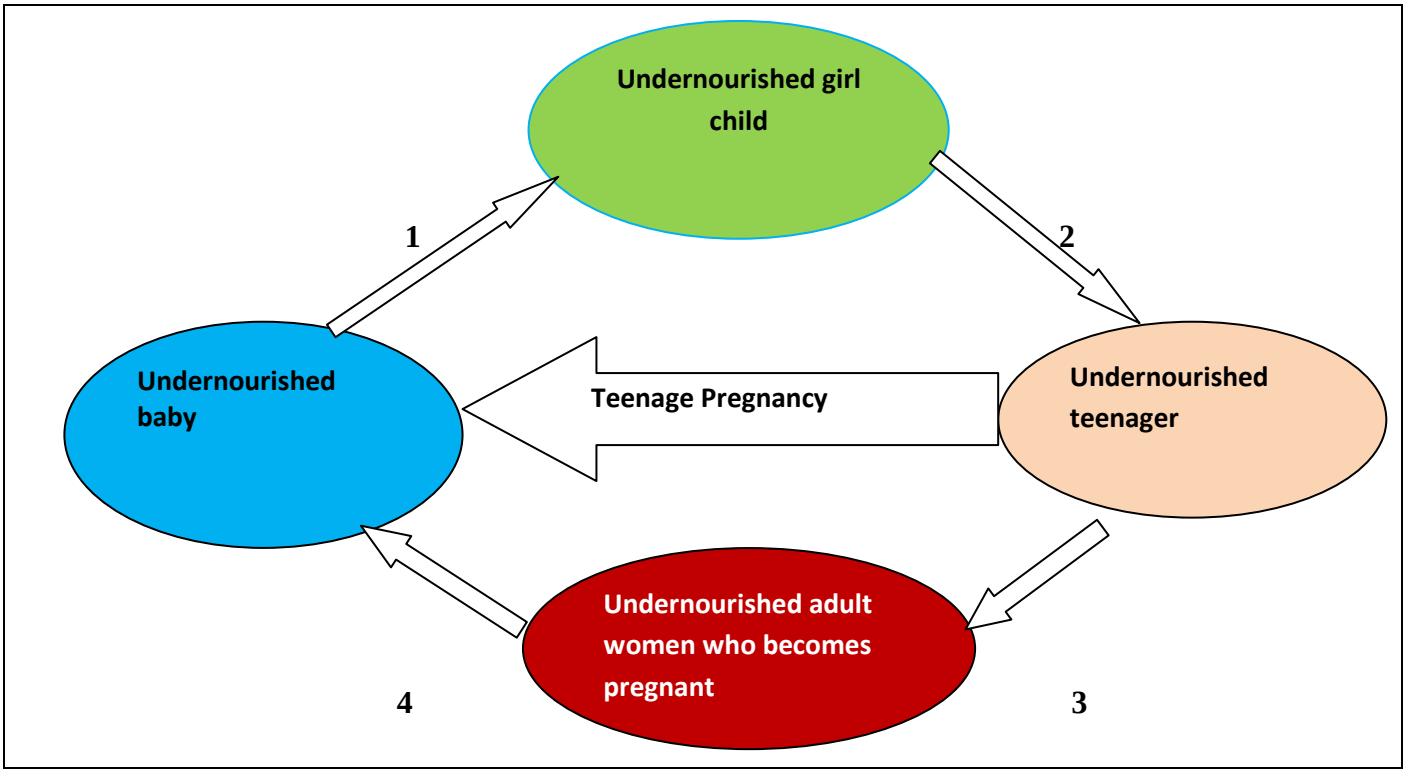


Table 1: Different nutrition and health interventions that can be implemented at each stage to break the under nutrition cycle:

Actions for the child (stage 1)	Actions for the teenage girl (stage 2)	Actions for adult women (stage 3)	Actions for the developing child/fetus to prevent low birth weight (stage 4)
1. **Prevent growth failure by:** • Encouraging early initiation of breastfeeding. • Providing exclusive breastfeeding from 0 to 6 months. • Promoting optimal complementary feeding practices. • Feeding a sick child frequently. 2. **Non-feeding actions to break the under nutrition cycle at this stage include:** • Practicing good hygiene. • Attending immunization sessions. • Using insecticide-treated bed nets to prevent malaria. • Deworming. • Preventing and treating infections.	**Promote appropriate growth by:** • Eating adequate amounts of nutritious foods. Eating a variety of locally available foods. • Delaying the first pregnancy until growth is completed (usually 20 to 24 years). • Preventing and seeking early treatment of infections. • Encouraging parents to give girls and boys equal access to education; under nutrition decreases when girls/women receive more education. • Encouraging families to delay marriage for young girls. • Avoiding processed/fast foods. • Avoiding intake of coffee/tea with meals. • Practicing good hygiene. • Using insecticide-treated bed nets to prevent malaria.	**Improve women's nutrition and health by:** • Consuming different types of locally available foods. • Preventing and seeking early treatment of infections. • Practicing good hygiene. • Delaying the first pregnancy until at least 20 years of age and encouraging couples to use appropriate family planning methods. • Encouraging men‘s participation. • Using insecticide-treated bed nets to prevent malaria. • Supporting equal access to education for girls and boys.	**Improve women's nutrition and health during pregnancy by:** • Increasing the food intake during pregnancy by eating one extra meal. • Consuming different types of locally available foods. • Giving iron, folate, and other recommended supplementation. Preventing and seeking early treatment of infections • Encouraging good hygiene practices. • Decreasing energy expenditure by resting more. • Delaying the first pregnancy until at least 20 years of age. • Encouraging men’s participation.

Session 5: Optimal Infant and Young Child Feeding

Introduction

5.1 Breastfeeding

Breastfeeding is the best method of providing ideal food for the healthy growth and development of infants. As a global public health recommendation, infants should be exclusively breastfed for the first 6 months of life to achieve optimal growth, development and health. If they are to succeed in breastfeeding exclusively, mothers need skilled practical help to build their feeding technique and prevent or resolve breastfeeding problems. The counselor can play a crucial role in the successful practice of exclusive breastfeeding during the first 6 months and continuation of breastfeeding with optimal complementary feeding up to the age of 24 months.

Learning objectives

1. Describe optimal breastfeeding practices.
2. Describe optimal complementary feeding practices for children 6 to 24 months of age.
3. Describe feeding practices for a sick child.

Key information

- A non-breastfed infant has a greater risk of death. In the first 6 months, a non-breastfed baby is 14 times more likely to die than an exclusively breastfed baby.
- A non-breastfed child is prone to underdevelopment: retarded growth, underweight, stunting and wasting due to higher infectious diseases such as diarrhea and pneumonia.
- Breast milk contains all the nutrients the baby needs, including vitamin A and antibodies that protect against diseases, especially diarrhea and respiratory infections.
- The infant benefits from colostrum, the first breast milk the baby receives after birth. It has a high concentration of nutrients and protects against illness and diseases. Colostrum acts as a laxative, cleaning the infant's bowels.

Use counseling cards (CC) 8 Early initiation of breastfeeding; 9 Proper positioning and attachment; 10 Exclusive breastfeeding.

Resource 15: Recommended breastfeeding practices and possible counseling discussion points

Recommended breastfeeding practices	Possible counseling discussion points Note: Choose two or three most relevant to mother's situation and add other discussion points from personal knowledge.
Place infant skin-to-skin with mother immediately after birth.	☐ Skin-to-skin with mother keeps newborn warm and helps stimulate bonding. ☐ Skin-to-skin helps the "let down" of the colostrum/milk. ☐ It is important to continue putting the baby to the breast to stimulate milk production and let down.
Initiate breastfeeding within the first hour of birth.	☐ Make sure baby is well attached. ☐ This first milk [use local word] is called colostrum. It is yellow and full of antibodies that help protect your baby. ☐ Colostrum provides the first immunization against many diseases. **CC 8 Early initiation of breastfeeding**
Breastfeeding in the first few days.	☐ Breastfeeding frequently from birth helps the baby learn to attach and helps to prevent engorgement and other complications. ☐ In the first few days, the baby may feed only 2 or 3 times/day. If the baby is still sleepy on day 2, the mother may express some colostrum and give it from a cup. ☐ Give nothing else—no water, no infant formula, no other foods or liquids—to the newborn.
Exclusively breastfeed (no other food or drink) from birth to 6 months.	☐ Breast milk is all the infant needs for the first 6 months. ☐ Do not give anything else to the infant before 6 months, not even water. ☐ Breast milk contains all the water a baby needs, even in a hot climate. ☐ Giving water will fill the infant and cause less suckling and less breast milk will be produced. ☐ Water and other liquids and foods for an infant less than 6 months can cause diarrhea. **CC 10 Exclusive breastfeeding**

Breastfeed frequently, day and night.	Frequent breastfeeding (8-12 times each day/night) increases the production of breast milk. More suckling (with good attachment) makes more breast milk. **CC 13 Breastfeeding day and night**
Continue breastfeeding when infant or mother is ill.	Breastfeed more frequently during infant illness. The nutrients and immunological protection of breast milk are important to the infant when mother or infant is ill. Breastfeeding provides comfort to a sick infant. **CC 24 How to feed a sick baby from 0-6months**
Avoid feeding bottles.	Foods or liquids should be given by cup to reduce nipple confusion and the possible introduction of contaminants. **CC 18 Hygiene** **CC 14 What to do when separated from your baby**

5.1. Common causes of breastfeeding difficulties and ways to overcome them

- Not enough milk
- Crying baby
- Refusal to breastfeed
- Working mother

5.1.1Not enough milk

One of the most common reasons for a mother to stop breastfeeding is that she thinks she does not have enough milk. Almost all mothers can produce enough breast milk for one or even two babies. Usually, even when a mother thinks that she does not have enough breast milk, her baby is in fact getting all that he/she needs. Sometimes a baby does not get enough breast milk; but it is usually because he/she is not suckling enough or not suckling effectively (see Session 3 How breastfeeding works). It is rarely because the mother cannot produce enough milk. It is important not to think about *how much milk a mother can produce*, but about *how much milk a baby is getting*.

- For the first 6 months of life, a baby should gain at least 500 grams each month.
- If a baby does not gain 500 grams in a month, he/she is not gaining enough weight.
- Look at the baby‘s growth chart (if available,) weigh the baby, then arrange to weigh him again in one week‘s time.
- An exclusively breastfed baby who is getting enough milk usually passes diluted urine at least 6-8 times in 24 hours.
- A baby who is not getting enough breast milk passes urine less than 6 times a day (often less than 4 times a day).
- The baby’s urine is concentrated and may be strong smelling and dark orange in color if receiving too little breast milk.
- If a baby is having other fluids (water) as well as breast milk, you cannot be sure he is getting enough breast milk if he is passing lots of urine.

Possible signs that a baby is not getting enough breast milk:

- Baby is not satisfied after breastfeeding and cries often.
- Very frequent and long breastfeeds.
- Baby refuses to breastfeed.
- Baby has hard, dry, green or infrequent stools.
- No milk comes out when mother expresses.

The reasons are arranged in four columns: (1) Breastfeeding factors; (2) Mother: psychological factors; (3) Mother: physical condition; (4) Baby's condition.

Breastfeeding factors	**Mother: psychological factors**	**Mother: physical condition**	**Baby's condition**
Delayed start Feeding at fixed times Infrequent feeds No night feeds Short feeds Poor attachment Bottles, pacifiers Other foods Other fluids (water, teas)	Lack of confidence Worry, stress Dislike of breastfeeding Rejection of baby Tiredness	Contraceptive pill Diuretics Pregnancy Severe malnutrition Alcohol Smoking Retained piece of placenta (rare) Poor breast development (very rare)	Illness Abnormality
These are COMMON		**These are NOT COMMON**	

Key points:

- Psychological factors are often behind the breastfeeding difficulties—for example, lack of confidence causes a mother to give bottle feeds.
- It is not common for a mother to have a physical difficulty in producing enough breast milk.
- If the baby is not getting enough breast milk, you need to find out why, so that you can help the mother.
- If the baby is getting enough breast milk, but the mother thinks that he/she is not, you need to find out why she doubts her milk supply so that you can build her confidence.

For babies who **are not** getting enough breast milk:

- Use your counseling skills to make an accurate feeding assessment.
- Observe a breastfeed to check positioning and attachment and to look for bonding or rejection.
- Use your observation skills to look for illness or physical abnormality in the mother or baby.

- The solutions you suggest to the mother will depend upon the cause of the insufficient milk.
- Always remember to arrange to see the mother again soon.

For babies who **are** getting enough breast milk but the mothers **think** they are not:

- Use your counseling skills to make an accurate feeding assessment.
- Explore the mother's ideas and feelings about her milk supply and pressures she may be experiencing from other people regarding breastfeeding.
- Observe a breastfeed to check positioning and attachment and to look for bonding or rejection.
- Praise the mother about good points in her breastfeeding technique and her baby's development.
- Always remember to arrange to see the mother again soon.

5.1..2 Crying baby

Scenario 1

Almaz says she does not have enough milk. Her baby is three months old and crying"all the time." Her baby gained 200g last month. Almaz manages the family farm by herself, so she is very busy. She breastfeeds 2 or 3 times at night, and about 2 times during the day when she has the time. She does not give her baby any other food or drink.

Do you think her baby is getting enough milk?
Why is Almaz's baby not getting enough breast milk?
Can you suggest how Almaz could give her baby more breast milk?

Many mothers start unnecessary foods or fluids because they think that their baby 'cries too much'. They think that their babies are hungry, and that they do not have enough milk. These additional foods and drinks do not make a baby cry less. Sometimes a baby cries more. A baby who cries a lot can upset the relationship between him and his mother, and can cause tension among other members of the family. An important way to help a breastfeeding mother is to counsel her about her baby's crying.

1. What are the reasons for a crying baby?

Reasons why babies cry	
Discomfort	(dirty, hot, cold)
Tiredness	(too many visitors)
Illness, pain, or colic	(changed pattern of crying)
Hunger	(not getting enough milk, growth spurt)
Mother's food	(any food, sometimes cow's milk)
Drugs mother takes	(caffeine, cigarettes, other drugs)
They want to be held	

Some of these causes may be new to you, so we will discuss them briefly.

- Hunger due to growth spurt:
  - A baby may become very hungry for a few days because he is growing faster than usual, especially at the ages of 2 weeks, 6 weeks and 3 months.
  - Encourage frequent suckling.
- Mother‘s food:
  - Sometimes a mother will notice that her baby is upset when she eats a particular food.
  - It can happen with any food so there are no special foods to advise mothers to avoid, unless she notices a problem.
- Colic:
  - Some babies cry a lot without any noticeable cause.
  - The baby may pull up his legs as if he has abdominal pain.
  - The baby may appear to want to suckle, but it is very difficult to comfort him.
  - Babies who cry in this way may have very active bowels or gas, but the cause is not clear. This is called colic.
  - Colicky babies tend to grow well and the crying usually decreases after the baby is 3 months old.
- Skin-to-skin contact: Some babies who cry a lot need to be held and carried more.

Key points:

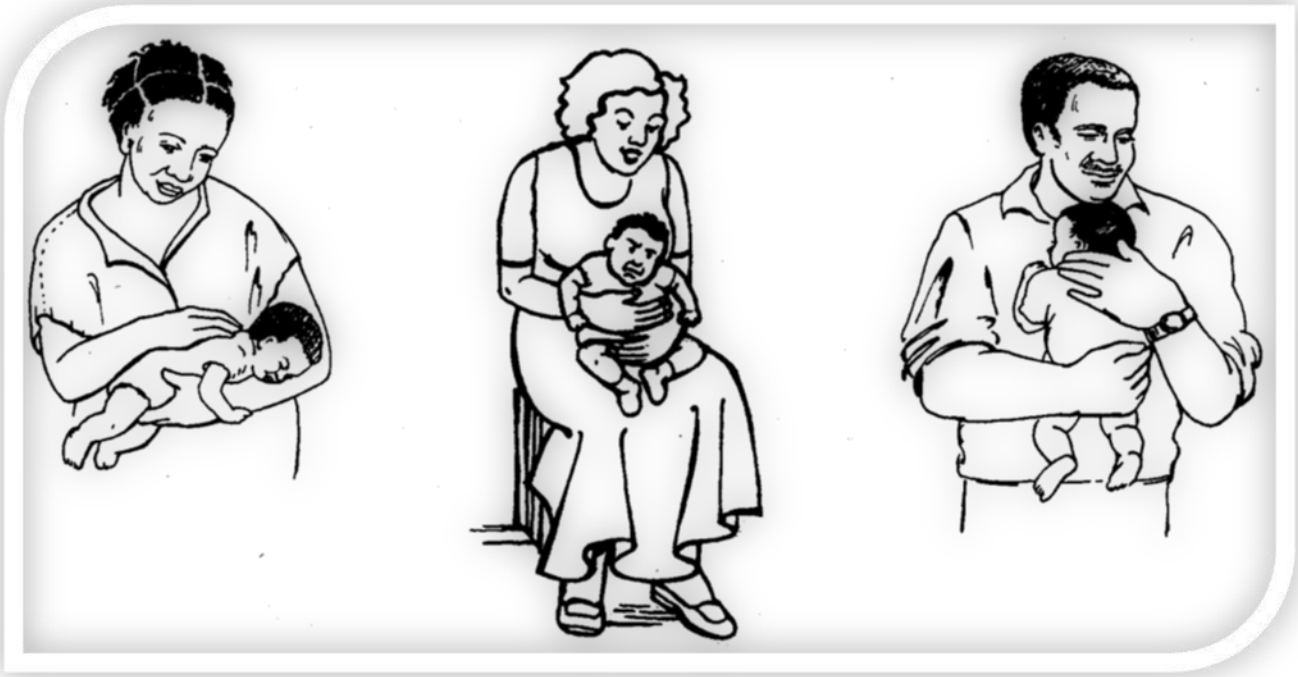
- Try to determine the cause of the crying. Use your counseling skills to make an accurate assessment.
- Observe a breastfeed to check the baby‘s position, attachment, and the length of the feed.
- Make sure the baby is not ill or in pain. Check the baby’s growth and refer if necessary.

Figure 6.1: Some different ways to hold a colicky baby

a. Holding the baby along the forearm

b. Holding the baby around his abdomen, on your lap

c. Father holding the baby against his chest



Scenario 2

Chaltu's baby is 3 months old. She says that for the last few days he has suddenly started crying and wants to be fed very often. She thinks that her milk supply has suddenly decreased. Her baby has breastfed exclusively until now and has gained weight well.

What relevant information can you give to Chaltu?

5.1..3 Refusal to breastfeed

Refusal by the baby is a common reason for stopping breastfeeding. However, it can often be overcome. Refusal can cause great distress to the baby's mother. She may feel rejected and frustrated by the experience. There are different kinds of refusal:

- Sometimes a baby attaches to the breast, but then does not suckle or swallow, or suckles very weakly.
- Sometimes a baby cries and fights at the breast, when his mother tries to breastfeed him.
- Sometimes a baby suckles for a minute and then comes off the breast choking or crying. He may do this several times during a single feed.
- Sometimes a baby takes one breast but refuses the other.

Reasons why babies may refuse to breastfeed

- Baby is ill, tired or in pain.
- Difficulty with breastfeeding technique.
- Changes that upsets the baby.
- Apparent, not real, refusal.

Causes of breast refusal

Illness, pain or sedation	Infection
	Sore mouth (thrush, teething)
Difficulty with breastfeeding technique	Use of bottles and pacifiers while breastfeeding Not getting much milk (e.g., poor attachment) Pressure on back of head when positioning Mother shaking breast Restricting length of feeds Difficulty coordinating suckle
Change that upsets baby (especially aged 3 to 12 months)	Separation from mother (e.g., mother returns to work) New caregiver or too many caregivers Change in the family routine Mother is ill Mother has breast problem (e.g., mastitis) Mother is menstruating Change in smell of mother
Apparent refusal	Newborn: rooting Age 4 to 8 months: distraction Older than 1 year: self-weaning

Helping a mother and baby to breastfeed again

Help the mother to do these things:

- Keep her baby close with no other caregivers.
  Have plenty of skin-to-skin contact at all times, not just during feeding.
  Sleep with her baby.

- Offer her breast whenever her baby is willing to suckle.
  Offer the breast when her baby is sleepy or after a cup feed.
  Offer when she feels her ejection reflex working.

- Help her baby to take the breast.
  Express breast milk into his mouth.
  Position the baby so that he/she can attach easily to the breast; try different positions.
  Avoid pressing the back of his head or shaking her breast.

- Feed her baby by cup using her own expressed breast milk.

Avoid using bottles, teats, and pacifiers

Scenario 3

Genet delivered a baby boy by vacuum extraction two days ago. He has a bruise on his head. When Gente tries to feed him, he screams and refuses. She is very upset and feels that breastfeeding will be too difficult for her. You watch her trying to feed her baby, and you notice that her hand is pressing on the bruise.

Relevant information: *"At the moment, the bruise is making breastfeeding painful for the baby. That is why he is crying and refusing to feed."*

5.1..4 Working mother

All mothers should learn how to express their milk so that they know what to do if the need arises. All health workers who care for breastfeeding mothers should teach mothers how to express their milk. Working mothers can leave expressed breast milk with the caregiver while they are at their work place.

How to feed a baby by cup

- Hold the baby sitting upright or semi-upright on your lap.
- Place the estimated amount of milk for one feed into a small cup.
- Hold the cup to the baby's lips and tip the cup so that the milk just reaches the baby's lips. The cup rests lightly on the baby's lower lip, and the edges of the cup touch the outer part of the baby's upper lip.
- The baby becomes alert and opens his mouth and eyes. A low-birth-weight (LBW) baby starts to take the milk into his mouth with his tongue. A full term or older baby sucks the milk, spilling some of it.
- DO NOT POUR the milk into the baby's mouth. Just hold the cup to his lips and let him take it himself.
- When the baby has had enough, he closes his mouth and will not take any more. If he has not taken the calculated amount, he may take more next time, or you may need to feed him more often.

Expressing milk is useful to:

- Leave breast milk for a baby when the mother goes out or goes to work
- Feed a low-birth-weight baby who cannot breastfeed
- Feed a sick baby who cannot suckle enough
- Keep up the supply of breast milk when a mother or baby is ill
- Prevent leaking when a mother is away from her baby
- Help a baby to attach to a full breast
- Help with breast health conditions, e.g., engorgement (see Session 20)

Use counseling card CC 14

Practical support for mothers at the facility level

Resource 2: Breastfeeding observation job aid

Mothers name …… Date ……
Baby's name…… Baby's age……

Signs that breastfeeding is going well

Mother:
Mother looks healthy
Mother is relaxed and comfortable
Signs of bonding between mother and baby

Baby
Baby is calm and relaxed
Baby reaches for breast if hungry

Breasts
Breasts look healthy
No pain or discomfort
Breast well supported with fingers

Baby's position
Baby's head and body in line
Baby's head close to the mother's body
Baby's whole body supported
Baby approaches breast, nose to nipple

Baby's attachment
More areola seen above baby's top lip
Baby's mouth open wide
Lower lip turned outwards
Baby's chin touches breast

Suckling
Slow, deep sucks with pauses
Cheeks round when suckling
Baby releases breast when finished
Mother notices signs of oxytocin reflex

Signs of possible difficulty

Mother:
Mother looks ill or depressed
Mother looks tense and uncomfortable
No mother/baby eye contact

Baby
Baby is restless or crying
Baby doesn't reach for breast

Breasts
Breasts look red, swollen, or sore
Breasts or nipple are painful
Breast held with fingers on areola away from nipples

Baby's position
Baby's head and neck twisted to feed
Baby not held close
Baby supported by head or neck only
Baby approaches breast, lower lip/chin to nipple

Baby's attachment
More areola seen below bottom lip
Baby's mouth not open wide
Lips pointing forward or tuned in
Baby's chin not touching breast

Suckling
Rapid shallow sucks
Checks pulled in when suckling
Mother takes off the breast
No signs of oxytocin reflex noticed

5.2 Complementary Feeding

Introduction

Complementary feeding means giving other foods in addition to breast milk. Additional foods and liquids are called complementary foods because they are a supplement to breastfeeding and are not sufficient on their own. Complementary foods must be nutritious and in adequate amounts so the child can continue to grow.

During the period of complementary feeding, the young child gradually becomes accustomed to eating family foods, though breastfeeding continues to be an important source of nutrients and protective factors until the child is at least 2 years old.

At 6 completed months, babies need to learn to eat thick porridge, puree and mashed foods as these foods provide more energy than liquids. Six months is an appropriate age because they:

- show interest in other people eating and start to reach for food
- like to put things in their mouth
- can control their tongue better to move food around their mouth
- start to make up and down 'munching' movements with their jaws.

In addition, at this age, babies' digestive systems are mature enough to begin to digest a range of foods.

The nutritional status of a child affects overall health. Health is not only growth and development but also the ability to fight off and recover from illness. Health staff should be aware of the nutritional status of children and promote diversified feeding practices.

Learning objectives

- Describe optimal complementary feeding practice.
- Identify different types of local foods that can be used as complementary foods.
- Explain how complementary foods can be enriched.
- Explain and demonstrate the appropriate thickness/consistency of complementary foods for different age groups.
- Explain the frequency and amount of complementary foods for different age groups.
- Understand active/responsive feeding practices.
- Practical session on complementary feeding in the classroom.

5.2.1 Types of foods and how to enrich them

<table>
<tr>
<td rowspan="2">Staples:

grains such as maize, wheat, barley, teff, millet , sorghum and roots crops such as Kocho, cassava and potatoes</td>
<td>Legumes:
beans, lentils, chickpeas, and peas</td>
<td rowspan="2">Animal-source foods:
such as minced meat, dried meat (kuwanta) powder, chicken, fish, liver, eggs, milk and milk products</td>
</tr>
<tr>
<td>Oil/butter

Iodized salt</td>
</tr>
<tr>
<td colspan="3">

Vitamin A-rich fruits & vegetables such as mango, papaya, dark-green leaves, carrots, sweet potato and pumpkin
Other fruits and vegetables such as banana, pineapple, avocado, tomato, beets and cabbage

</td>
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</table>

Key points:

Make sure the child gets vitamin A supplementation twice a year from 6 months to 5 years of age.

Encourage the consumption of vitamin A rich foods such as yellow-colored fruits (papayas, mangoes, oranges, carrots, pumpkins, and orange-flesh sweet potatoes), dark green vegetables, organs (liver), and animal sources (eggs, milk, butter, cheese) and vitamin A-fortified foods.

Iron

After 6 months, the baby‘s iron needs must be met by the foods he or she eats.

- The best sources of iron are animal foods, such as liver, lean meats and fish. Other good sources are iron-fortified foods and iron supplements.
- Plant sources such as beans, peas, lentils and spinach are a source of iron as well.
- Eating vitamin C rich foods with iron, or soon after, increases the absorption of iron.
- Drinking tea and coffee with a meal reduces the absorption of iron.

Vitamin D

Expose the child to the sun on a daily basis to fulfill his/her vitamin D requirement. Vitamin D will help build strong bones and teeth.

Iodine

Cook family food with iodized salt and eat fish, if available. Iodine will help intellectual development.

Resource 5: Different types of local foods.

Staples: grains such as maize, wheat, barley, teff, millet, sorghum and roots crops such as Kocho, sweet potato, cassava and potatoes	
Legumes such as beans, chickpeas. lentils, and peas	
Vitamin A-rich fruits and vegetables such as mango, papaya, dark-green leaves, carrots, yellow sweet potato, pumpkin and **other fruits and vegetables** such as banana, pineapple, avocado, watermelon, tomato, eggplant and cabbage	
Animal-source foods including flesh foods such as minced meat, dried meat (kuwanta) powder, chicken, fish, liver, eggs, milk and milk products **Note: animal source foods should be started at 6 months**	 
Small amounts of oil or butter added to vegetables and other foods will provide extra energy. Infants need a very small amount (no more than half a teaspoon per day). It is also valuable not to skim the fat from boiled milk.	

How to enrich complementary foods

- Use Resource 7 to enrich complementary foods.
- Germination is one way to enrich foods.
- Add the six food groups to the child's meal.

Resource 7: Enriching complementary foods

Cereal or root crop based complementary foods can be enriched by:

1. Replacing **water** used for preparing porridges **with milk.**
2. Adding **butter/oil** which will enrich, thicken and make the porridge more energy dense, softer and easier to eat.
3. **Mixing legume flour** such as pea, chickpea or broad bean with the staple flour before cooking (use 1/4 legume flour to 3/4 cereal flour).
4. Adding **dried meat** (kuwanta) powder, finely minced meat or eggs.
5. Adding finely chopped **kale, spinach or carrots**.
6. Adding mashed **avocado**, banana or papaya.
7. Adding **iodized salt** after preparing complementary foods.

Note: All of the above actions will improve the nutrient quality of complementary foods.

- Animal source foods should be eaten as often as possible.
- Adding small amounts of an animal source food to the meal adds nutrients and is healthy for the child.
- Organ meats such as liver, heart and kidney are often less expensive and have more iron than other meats.

Preparation of animal foods

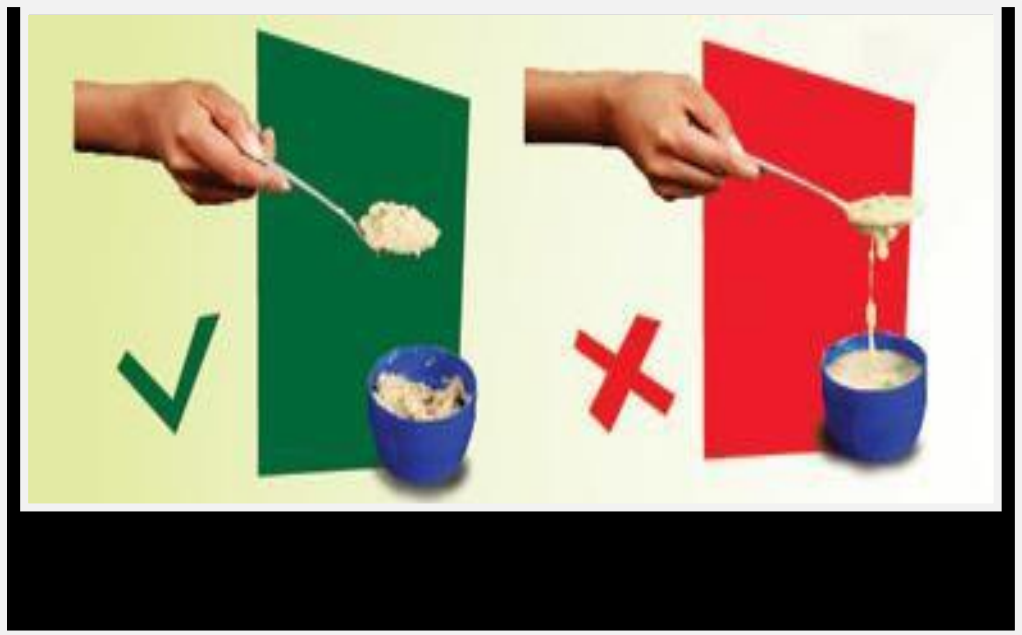
- Meat or organ meat can be finely minced to make it easier for the child to eat.

Fruits and vegetables

- Encourage families to eat orange/yellow-colored fruits and dark green vegetables.
- Promote home gardens and planting fast growing vegetables such as kale, carrots and tomatoes if a small plot of land near the home is available.
- Purchase seasonal fruits and vegetables from the local markets, if families can afford to do so.

5.2.2 Thickness or consistency of complementary foods

The consistency or thickness of foods makes a big difference to how well that food meets the young child's energy needs. Foods of a thick consistency help to fill the energy gap. Use Facilitator's Note: Thickness/consistency of complementary foods.



Facilitator's Note 4: Thickness/consistency of complementary foods

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1. ***Why do families not give thick food to infants?***
   - **Fear of chocking:** Families are usually afraid that thick foods are difficult for the baby to swallow and will choke the child or cause constipation.
   - Families think adding more water to complementary foods make them easier for the child to eat and suitable for bottle feeding.
2. ***What is the benefit of thick food?***
   - **Amount of water:** Cook porridge with less water to make it thicker which provides more energy.
   - Porridge that is thin does not provide enough energy or nutrients a child needs to grow strong and healthy.
3. ***When can babies start thick food?***
   - **At 6 months:** infants can eat pureed, mashed, and semi-solid foods. Beginning at 8 months, they can eat foods that they can hold in their hands, like a piece of fruit.
   - **At 12 months:** most children can eat family foods which are modified to meet their needs. Modification can be mashing or adding extra foods like mashed vegetables to the family foods.

</td>
<td>6 to 11 months</td>
<td>Start with small amount of soft porridge at 6 months.

Gradually increase to thick porridge.

Give finely mashed foods (fruits, boiled vegetables)</td>
</tr>
<tr>
<td>12 to 24 months</td>
<td>Family foods, chopped or mashed; enriched porridge</td>
</tr>
</table>

5.2.3 Frequency and amount of complementary foods

When a child starts to eat complementary foods, he needs time to get accustomed to the new taste and texture of the foods. A child needs to learn the skill of eating. Encourage families to start with 2-3 small spoonfuls of the food twice a day. As the child gets older, increase the amount of food offered. Give as much as the child will eat with active encouragement.

Resource 10: Recommended amount and frequency of child feeding per day

Age	Frequency	Amount
0 to 6 months	Breastfeed day and night as often as the child wants (at least 10-12 times)	**At 6 months (181 days) start with 2 to 3 tablespoons and gradually increase amount.**
6 to 11 months	3 meals plus frequent breastfeeds 1 to 2 snacks may be offered	**Increasing gradually to 3 full cups**
12 to 24 months	**4 meals plus breastfeeds** **1 to 2 snacks may be offered**	**4 full cups**

Key information

Importance of snacks throughout the day

- In addition to complementary foods, children need snacks to fill energy gaps.
- Snacks are foods eaten between meals and they are convenient ways to give a young child extra food needed to supplement the child's energy and micronutrient requirements.
- Snacks should be easy to prepare and provide both energy and nutrients.

Note: Tea and coffee contain compounds that can interfere with iron absorption and thus are not recommended for young children. Sugary drinks, such as soda, should be avoided because they contribute no value other than energy and will decrease the child's appetite for more nutritious foods.

Resource 11: Key Messages: Amount & Frequency of Complementary Foods for 6 to 24 months

Who	Action	Why
Mother/ Father	□ Start soft thick porridge when baby is exactly 6 months old □ Start with 'tastes' (2-3 tablespoons) and gradually increase amount.	Starting at 6 months, feeding only breast milk will not meet the needs of the growing baby; babies should be fed complementary foods at 6 months in addition to breast milk. Starting at 6 months, babies can swallow soft thick porridge; you don't have to worry about possible chocking. By 8 months, the baby should begin eating finger foods such as pieces of ripe mango, papaya, avocado, banana, etc.
	□ From 6 -11 months, feed 2 to 3 meals plus frequent breastfeeds, feed 1 to 2 snacks □ From 12 – 24 months feed 3 to 4 times and continue breastfeeding, also feed 1 to 2 snacks.	Babies cannot eat more food at one time because they have small stomachs; they need small, frequent feedings.A 12 months of age, start to feed family foods, chopped or mashed, and if necessary, enriched porridge. Feed soft thick porridge enriched with dried meat powder, minced kale, pumpkin, etc. at least 3-4 times a day along with 1-2 other solid foods (*mekses*) each day to ensure healthy growth. As your baby grows older, feed more food at each meal in order to ensure that he/she is eating enough to maintain healthy growth. If babies are not fed adequate food, they cannot grow well; their physical and brain development could be affected.

5.2.4 Active/responsive feeding

Facilitator's Note 5: Active responsive feeding

What does active feeding mean?	□ When feeding young infants, the mother/caregiver is alert and responsive to the child's clues for hunger and fullness. □ Encouraging and stimulating the child to eat is referred to as active or responsive feeding. Active/responsive feeding increases a child's dietary intake.
How can mothers or caregivers practice active/responsive feeding?	□ Be sensitive to child's hunger and fullness signs. □ When the child is old enough, offer foods that the child can take and hold as children often want to feed themselves. Make sure most of the food goes into his/her mouth. □ Feed slowly and patiently; encourage children to eat, but do not force them. □ Congratulate the child when he/she finishes the food.
What if children refuse to eat?	□ If children refuse to eat, try out different food combinations, tastes, consistency, methods of encouragement or wait and offer again. □ Minimize distractions during meals if the child loses interest easily. □ Remember that feeding times are periods of learning and love; talk to children and play with them during feeding; use eye-to-eye contact.
Should mothers only feed the child?	□ Fathers, family members (older children), child caregivers can participate in active/responsive feeding.
Can the child eat with older siblings?	□ Have a separate, colorful and attractive plate for infants and young children. □ Feeding a child from his/her own plate helps the mother/caregiver know if the child is getting adequate food.

Resource 12: Key Actions: Active Feeding

WHO?	ACTION	WHY?
Mother	Be patient and actively encourage your baby to eat all its food in order to grow healthy.	At first the baby may need time to get used to eating foods other than breast milk so have patience and take enough time for feeding, even using play to help the baby eat. Make the time for eating special.
		Use a separate plate to feed the child to make sure he/she eats all the food given.
		Forced feeding will discourage babies and young children from eating.
		As they are too little to feed themselves, babies need to be fed directly to make sure they eat all the food given to them.
		As they are too little to feed themselves, babies need to be fed directly to make sure they eat all the food given to them.
		Even when older, young children should be supervised during mealtime to make sure they eat all the food put on their plate.

Resource 3: PRACTICAL DISCUSSION CHECKLIST

Practical skills are best developed by introducing and demonstrating the skills, observing participants as they practice the skills and giving feedback to participants on how well they performed. Feedback should include praising participants for things done well, and giving gentle suggestions for how to overcome difficulties. Use the checklist below to help guide your feedback discussions.

Questions to ask after each participant completes his/her turn practicing (either in the clinic or using counseling stories)

To the participant who practiced:

- What did you do well?
- What difficulties did you have?
- What would you do differently in the future?

To the participants who observed:

- What did the participant do well?
- What difficulties did you observe?

Listening and learning skills (give feedback on the use of these skills in all practical sessions)

- Which listening and learning skills did you use?
- Was the mother willing to talk?
- Did the mother ask any questions? How did you respond?
- Did you empathize with the mother? Give an example.

Confidence and support skills (give feedback on the use of these skills in all practical sessions)

- Which confidence and support skills were used?
  (Check for praise and for two relevant suggestions)
- Which skills were most difficult to use?
- What was the mother's response to your suggestions?

Key messages for complementary feeding (give feedback on the use of these skills in practical sessions)

- Which messages for complementary feeding did you use?
  (Check for "only a few relevant messages")
- What was the mother's response to your suggestions?

General questions to ask at the end of each practical session (in the clinic or using counseling stories)

- What special difficulties or situations helped you to learn?
- What was the most interesting thing that you learned from this practical session?

Resource 4: Observation checklist for infant and young child

Feeding assessment of mother/child

Name of counselor: _____

Name of observer: _____

Date of visit: _____

(√ for yes and × for no)

Did the counselor

Use listening and learning skills:

□ Keep head level with mother/parent/caregiver?
□ Pay attention? (eye contact)
□ Remove barriers? (tables and notes)
□ Take time?
□ Use appropriate touch?
□ Ask open-ended questions?
□ Use responses and gestures that show interest?
□ Repeat back what the mother said?
□ Avoid using judging words?
□ Allow mother/parent/caregiver time to talk?

Use building confidence and giving support skills:

□ Accept what a mother thinks and feels?
□ Listen to the mother/caregiver's concerns?
□ Recognize and praise what a mother and baby are doing correctly?
□ Give practical help?
□ Give relevant information?
□ Use simple language?
□ Make one or two suggestions, not commands?

ASSESSMENT

(√ for yes and × for no)

Did the counselor

□ Assess age accurately?
□ Check mother's understanding of child growth curve? (if GMP exists in area)
□ Check on recent child illness?

5.2.5 Practical session on complementary feeding in the classroom

Role-play **(20 minutes)**

Scenario 1. Abebe is 8 months old. He was exclusively breastfed up to 6 months. After 6 months his mother prepared 'mitin' and is feeding gruel with a bottle. His grandmother thinks that he is too young to eat other foods. Abebe has diarrhea and the mother came to a clinic to get treatment for diarrhea.

Counsel this mother **(use CC 18 Hygiene, 19 Complementary feeding, 20 Variety of foods)**

Scenario 2. A mother came to a clinic with her 13-month-old child Fatuma. The health worker asked Fatuma about her feeding practices. Fatuma is still breastfeeding and she is getting injera with shiro once a day.

Counsel this mother (**use CC 18 Hygiene, 23 Infant feeding 12-23 months**)

Practical session at a clinic

After completing this session, participants will be able to: demonstrate how to gather information about complementary feeding using counseling skills and the FOOD INTAKE JOB AID, 6-23 MONTHS.

Provide information about complementary feeding and continuing breastfeeding to a mother of a child 6-23 months old.

Do not offer suggestions for treatment of an ill child.

When you talk with a mother:

- Introduce yourself to the mother and ask permission to talk with her. Introduce the others in your group and explain you are interested in learning about feeding young children.
- You may wish to say you are taking a course.
- Try to find a chair or stool to sit on, so you are at the same level as the mother.
- Practice as many of the counseling skills as possible as you gather information from the mother using the FOOD INTAKE JOB AID, 6-23 MONTHS.
- Listen to what the mother is saying and try not to ask a question if you have already been told the information.
- Fill out the FOOD INTAKE JOB AID, 6-23 MONTHS as you listen and learn from the mother.
- Use the information you have gathered to praise two things that she is doing well and offer two or three suggestions for improvement.
- Be careful not to give a lot of advice.
- Answer any questions the mother may ask as best you can. Ask your trainer for assistance as necessary.

The participants who are observing can mark a ☺ on the COUNSELLING SKILLS CHECKLIST for every skill that they observe their partner practicing. Remember to observe what the 'counselor' is doing rather than thinking about what you would say if you were talking to the mother. The observers should not ask the mother any questions. When you have finished talking with a mother, thank her and move away.

Briefly discuss with the group and your trainer what you did and what you learned and clarify any questions you may have about conducting the exercise. Discuss what practices you praised, what feeding problems you noticed, information and suggestions that you offered, and counseling skills you used. Find another mother and repeat the exercise with a different participant doing the counseling.

Notice the following:

. If children eat any food or have any drinks while waiting
. Whether children are given a bottle or pacifier while waiting
. General interaction between mothers and children
. Any posters or other information on feeding in the area

Use the PRACTICAL DISCUSSION CHECKLIST to guide you as you give feedback to the participants.

Discuss the findings as a whole group **(15 minutes)**

Return to the whole class group. Discuss what the participants learned from listening to the mothers and from the completed FOOD INTAKE JOB AID, 6-23 MONTHS.

What did you observe in general looking around the health center?

Look at the FOOD INTAKE JOB AIDS, 6-23 MONTHS which you filled in.

- What practices are mothers using that you could praise and encourage?
- What areas need improvement?
- Give some examples of suggestions you made to mothers about complementary feeding practices.
- Would these suggestions be easy to carry out?

Resource 13: FOOD INTAKE JOB AID, 6-23 MONTHS

FOOD INTAKE JOB AID, 6-23 MONTHS		
Child's name		
Date of birth	**Age of child at visit**	
Feeding practice	**Yes / number where relevant**	**Key Message given**
Child received breast milk?		
How many meals of a thick consistency did the child eat yesterday? (use consistency photos as needed)		
Child ate an animal-source food yesterday? (Meat/fish/poultry/eggs)?		
Child ate a dairy product yesterday?		
Child ate pulses, nuts or seeds yesterday?		
Child ate a dark-green or yellow vegetable or yellow fruit yesterday?		
Child ate sufficient number of meals and snacks yesterday for his/her age?		
Quantity of food eaten at main meal yesterday appropriate for child's age?		
Mother assisted the child at meals times?		
Child took any vitamin or mineral supplements?		
Child ill or recovering from an illness?		

5.3 Feeding and Care of the Sick child

Illness is depleting energy from our body. A sick child has to be fed more frequently and during rehabilitation he/she needs one extra meal for the first two weeks after illness which helps him/her to gain the lost energy.

Key information

- Some of the children you see for feeding counseling may be ill or recovering from an illness.
- Children who are ill may lose weight because they have little appetite or their families may believe that ill children cannot tolerate much food.
- If a child is ill frequently, he or she may become malnourished and therefore be at higher risk of increased illness. Children recover more quickly and do not lose less weight if they continue to eat and breastfeeding while they are ill.
- Children who eat well when healthy are less likely to falter in growth from an illness and more likely to recover faster. They are better protected.
- Breastfed children are protected from many illnesses. Special care needs to be given to those who are not breastfed and who do not have this protection.

Relationship between feeding and illness

- A sick child (diarrhea, acute respiratory infection [ARI], measles and fever) usually do not feel like eating, but needs extra strength to fight the illness.
- Strength comes from the food he or she eats.
- A child who doesn‘t eat enough is more likely to suffer from long-term illness and malnutrition that may result in a physical or mental disability.
- If the child does not eat or breastfeed during sickness, he or she will take more time to recover and may die.
- It is very important to encourage a sick child to continue to breastfeed or drink fluids and eat during illness, and to increase food intake during recovery in order to quickly regain strength.
- Take advantage of the period after illness when the appetite is back to make sure the child makes up for loss of appetite during illness.

Help mothers feed sick children

How to feed a sick baby from birth to 6 months

Breastfeed your baby more frequently when the baby is sick. It is important to feed your baby more often to help fight the illness, reduce weight loss and recover quickly.

- Continue to breastfeed your baby even if the baby is sick or has diarrhea.
- Express milk and give it to the baby if the baby is too weak to suck.
- Take your baby to the health facility for treatment when he/she is sick.
- Give the baby only medicines recommended by a health worker. Breastfeed your baby even more frequently after the baby recovers from illness. This will help the baby to regain his/her health, weight and growth.

When you are sick, you can continue to breastfeed your baby. You may need extra support and food during this time.

How to feed a sick child 6 to 23 months old (CC 25 How to feed sick child)

Breastfeed your child more frequently when the child is sick. Give more food and liquids than usual. Your sick child needs more food and liquids to make his/her body strong and able to fight the illness.

- Encourage your child to eat small amounts many times a day.
- Offer his/her favorite foods to encourage him/her to eat.
- Prepare the food in a way that will encourage the child to eat.
- Give foods those are easy to eat, such as thick porridge.
- Avoid giving food with spices.
- Continue to breastfeed and give food even when the child has diarrhea and is vomiting.
- If the child has diarrhea, give oral rehydration salts (ORS) and zinc tablets. Make ORS according to the instructions on the packet.
- Take the baby to the nearest health facility for treatment if he/she is seriously sick, has sores in the mouth or if the sickness gets worse.

When your child gets better, encourage the child to eat an extra meal of solid food each day. This will help the child to gain the lost weight and grow well again.

When you are sick, you can continue to breastfeed your baby. You may need extra food and support during this time.

Use counselling card CC 25 Feeding children during illness

Resource 15: Questions for discussion of feeding during illness and guidance for children who do not gain weight.

Key Questions

Feeding during illness-babies under 6 months

1. Do mothers/caregivers of babies under six months keep breastfeeding when their child is sick? Are there any situations when they would stop breastfeeding? Do they breastfeed more or less when the child is sick?
2. Are there other liquids or foods that mothers/caregivers provide to sick babies when they are under 6 months old?
3. Where do mothers/caregivers get advice on feeding babies who are less than 6 months old when they are sick?
4. Are there ways to prevent children from becoming sick at this age? How?

Feeding during illness—babies 6-24 months

1. Do mothers feed their babies 6-24 months normally when they are sick? What do they do differently?
2. Where do mothers go for advice on feeding children 6-24 months when they are sick?
3. Are there special foods or liquids that are given to sick children at this age?
4. Are there ways to prevent children from becoming sick at this age? How?

Session 6: Overview of HIV and Infant Feeding

Introduction

Breastfeeding is normally the best way to feed an infant. A woman infected with human immunodeficiency virus (HIV), however, can transmit the virus to her child during pregnancy, labor, delivery, or through breastfeeding. The aim of infant feeding practices in the context of HIV should not be just the prevention of HIV transmission but also ensuring the health and survival of infants – referred to as HIV-free survival.

In this session participants will learn infant feeding practices in the context of HIV. The session is prepared based on the new 2010 World Health Organization (WHO) recommendations.

Learning objectives

1. Explain when HIV can be transmitted from mother to child and the risk of transmission with and without interventions.
2. Describe infant feeding in the context of HIV.
3. Learn how to counsel a mother with an HIV exposed infant.

Risk of mother to child transmission of HIV

About two-thirds of infants born to HIV-infected mothers will not be infected, even without intervention, such as antiretroviral (ARV) prophylaxis or cesarean section. Not all babies born to HIV-infected mothers become infected with HIV. Exclusive breastfeeding during the first few months of life carries a lower risk of HIV transmission than mixed feeding, according to research.

When the mother takes ARVs from 14 weeks of pregnancy, the risk of transmission during pregnancy and labor is virtually nonexistent. Some studies have also shown that transmission during breastfeeding while using ARVs is as low as 1 in 100 infants.
Using an example of 100 HIV positive women, Table 1 below shows the risk of HIV transmission from mother to child in both scenarios: with and without intervention.

Table 1: Risk of HIV transmission from mother to child with and without interventions

Risk of HIV Transmission from HIV positive mother to infant	
Without intervention[1]	**With** intervention
If 100 HIV-positive women get pregnant, deliver, and breastfeed for 2 years[2]: • About 25 babies may be infected with HIV during pregnancy, labor, and delivery. • About 10 babies may be infected with HIV through breastfeeding, if breastfed for 2 years. • **About 65 of the babies will not get HIV.**	If 100 HIV-positive women and their babies take ARVs and practice exclusive breastfeeding during the first 6 months: • About 2 babies may be infected during pregnancy and delivery. • About 3 babies may be infected during breastfeeding. • **About 95 babies will not get HIV.** Note: The goal is to have infants without HIV, but still survive (HIV-free survival). Therefore, the risks of getting HIV through breastfeeding have to be measured against the risks of increased morbidity and mortality associated with not breastfeeding.

The bar chart below also shows infant outcomes with and without interventions[2]

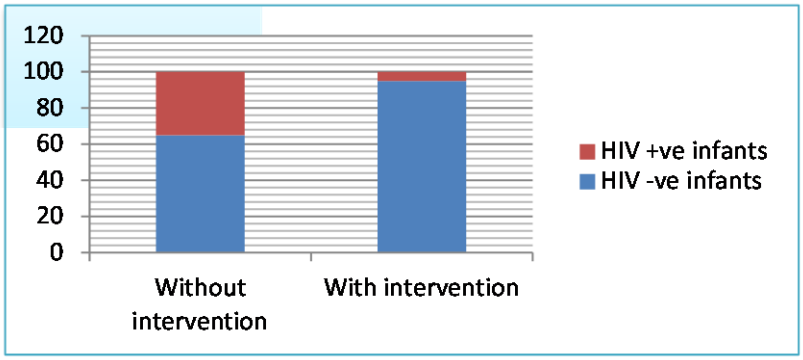

Figure 1: Rate of mother to child transmission of HIV with and without intervention

[1] Interventions to reduce mother-to-child transmission of HIV:
During pregnancy: HIV counseling and testing; ARVs prevent and treat sexually transmitted infections, malaria, and opportunistic infections, etc.
During labor and delivery: ARVs; keep delivery normal; minimize invasive procedures, etc.
During post-partum and beyond: ARVs, Support for exclusive breastfeeding; prevent and treat breastfeeding conditions; safe sex, etc.

[2] DeCock KM et al. Prevention of mother-to-child HIV transmission in resource-poor countries: translating research into policy and practice. *Journal of the American Medical Association*. 2000; 283(9):1175–1182.

1. Infant feeding in the context of HIV

In 2006, WHO developed guidance on how infants born to HIV-positive women should be fed. These recommendations, formulated in the absence of ARV interventions, suggested that breastfeeding should stop after the infant reaches 6 months as long as specific AFASS (affordable, feasible, acceptable, safe and sustainable) conditions were in place for replacement feed. Where AFASS criteria were not met, the recommendation was to continue breastfeeding. Since then evidence has shown that ARV interventions for either the HIV-infected mother or HIV-exposed infant can significantly reduce the risk of postnatal transmission of HIV through breastfeeding. With ARVs, breastfeeding has become dramatically safer. Based on the research findings, WHO developed a new guideline in 2010 that suggests how infants born to HIV-positive women should be fed. The following section describes infant feeding practices as recommended by the new WHO guidelines.

Recommended infant feeding practices

Definition of terms

- **Exclusive breastfeeding**: feeding infant only breast milk with no other food or drink (including water).
- **Replacement feeding:** giving an infant who is not receiving any breast milk a nutritionally adequate diet until the child can be fully fed on family food.
- **Mixed feeding:** giving infant breast milk plus other foods or drinks, including ready-to-use therapeutic foods (RUTF) before the age of 6 months.

Table 2: Recommended infant feeding practices based on new WHO recommendations

Recommended infant feeding practices based on new WHO recommendations[3]	
Key actions & recommendations	**Explanation**
1. Exclusive breastfeeding until 6 months, introduce complementary foods at 6 months, and continue breastfeeding until 12 months (all with ARVs).	• HIV-positive women are recommended to exclusively breastfeed their infant until 6 months, introduce complementary feeding at 6 months and continue breastfeeding until 12 months. This MUST be combined with either ARV for the women or ARV prophylaxis for the infant. ARV significantly reduces HIV transmission. • Adherence to ARVs for both mother and baby is important. ARV for either mother or infant should be provided as per national prevention of mother-to-child transmission (PMTCT) guidelines
2. Focus the counseling on the recommended option (breastfeeding and ARVs).	• While counseling the mother, information about feeding options should focus on the recommended option (breastfeeding plus ARVs). Alternative options (e.g., replacement feeding) can be provided if the mother asks.
3. If a mother insists on formula feeding, ALL of the following conditions need to be fulfilled: a) safe water and sanitation b) sufficient infant formula c) consistently clean preparation of formula d) exclusive formula feeding e) family support f) access to health care	The concept of AFASS (*affordable, feasible, acceptable, sustainable and safe*) that was adopted in previous recommendations as a condition for replacement feeding has proven difficult to translate into effective counseling for mothers. Instead use the following recommended conditions needed to safely formula feed: a) Safe water and sanitation are assured at the household level and in the community **and** b) The mother or caregiver can reliably provide sufficient infant formula milk to support normal growth and development of the infant **and** c) The mother or caregiver can prepare it cleanly and frequently enough so that it is safe and carries a low risk of diarrhea and malnutrition **and** d) The mother or caregiver can, in the first 6 months, exclusively give infant formula milk **and** e) The family is supportive of this practice **and** f) The mother or caregiver can access health care that offers comprehensive child health services.

[3] Guidelines on HIV and infant feeding: Principles and recommendations for infant feeding in the context of HIV and a summary of evidence: WHO, UNAIDS, UNFPA, and UNICEF, 2010.

4. Support gradual weaning from breastfeeding starting at 12 months.	• Starting at 12 months, a mother can stop breastfeeding gradually within a period of 1 month. • Gradual weaning will help avoid feelings of rejection for the baby and will prevent the mother from engorgement or blocked milk ducts which can lead to breast infections. • A mother can start by dropping one feeding, and allow a 2- to 3-day adjustment period for her baby and her milk supply. Replace the dropped feeding with affection, drinks or snacks. • During the weaning process, it is important for the mother to give extra attention to her baby. • A contact point at 12 months needs to be established to provide counseling and support.

Additional recommendations

- If an HIV-positive mother does not have access to ARVs, it is still advisable to recommend exclusively breastfeeding for the first 6 months, introduce complementary feeding at 6 months and continue breastfeeding until 12 months. Every effort should be made to refer the woman fort access to ARVs.
- If a woman is HIV-positive and her infant is tested positive, it is recommended that the infant be exclusively breastfed for the first 6 months, introduce complementary feeding at 6 months and continue breastfeeding for 2 years and beyond.
- If a woman is HIV-positive and her infant is tested negative or is of unknown status, it is still recommended that the infant be exclusively breastfed for the first 6 months, introduce complementary feeding at 6 months and continue breastfeeding until 12 months.
- If a woman's HIV status is unknown, the recommended practice is to exclusively breastfeed for the first 6 months, introduce complementary feeding at 6 months and continue breastfeeding for 2 years and beyond. Special effort should be made to refer any woman of unknown status for HIV counseling and testing service as soon as possible.

Counseling for mothers with HIV-exposed infants should include the following:

- Support for breastfeeding.
- Support for safe breastfeeding cessation at 12 months.
- Support for infant and young child feeding counseling around the time of infant HIV testing.
- Support for timely and appropriate introduction and continuation of complementary feeding.
- Adherence to ARVs for both mother and baby and counseling based on PMTCT guidelines.
- Counseling on infant feeding may need to take into account the progression of the mother's disease. Recent evidence suggests a very high rate of postnatal transmission in women with an advanced disease.
- An HIV-positive mother who chooses to breastfeed needs to use a good technique to prevent nipple fissure and mastitis, both of which may increase the risk of HIV transmission.

Session 7: Gender and Nutrition

Introduction

Men and women have unique and significant roles to play in improving nutrition. Linkages between gender and nutrition are present in various areas and act through different pathways, thereby offering multiple opportunities for synergy. Nutrition may be an entry point for addressing more sensitive gender issues through nutrition education, school-based and agriculture extension, among others. Gender matters because initiatives to improve nutrition cannot achieve lasting success without taking into consideration the social, economic and biological differences between men and women and, in particular, the gender inequalities which stand in the way of good nutrition.

This session will provide the basic concepts on gender and sex, the importance of gender analysis and gender mainstreaming steps in nutrition and livelihood programs.

Learning objectives

1. To equip the participants with basic concepts and ideas on gender and sex
2. To discuss the gender division of labor in communities and its effects on the nutrition situation women & children.
3. To describe the concept of gender analysis and its relevance for gender integration
4. To explain concept of gender mainstreaming and gender integration in nutrition interventions.

Sex and Gender concepts

Sex

Sex refers to biological attributes that identify a person as a male or female. These attributes are generally permanent, universal and cannot be changed over time.

Gender

Refers to the socially constructed roles and responsibilities of women and men in a given culture or location. Gender attitudes and behaviors are learned and can be changed. What are some of the situations in which we see gender differences?

Social: Different perceptions of women's and men's social roles: the man seen as head of the household and chief bread-winner; the woman seen as nurturer and care-giver.

Political: Differences in the ways in which women and men assume and share power and authority: men more involved in national- and higher-level politics; women more involved at the local level in activities linked to their domestic roles.

Economic: Differences in women's and men's access to careers and income, control of financial and other productive resources: livestock and land ownership. .

In most instances, gender is equated with women. However, paying attention to gender does not means focusing on women as beneficiaries, but focusing on gender analysis and incorporating the needs of girls, boys, men and women at all levels of interventions.

Gender Equity: is the process of being fair and justice in the distribution of responsibilities and benefits between men and women. In order to be fair, measures must be taken to compensate for historical and social disadvantages that limit women and men from operating on a level playing field.This may require a redistribution of power & resources

Gender Equality

Ensuring gender equality means giving the same means, and opportunities to men, women, boys and girls so that they enjoy the same status within a society, being free to develop their personal abilities and make choices without the limitations set by strict gender roles (UNFPA, 2008).

Promoting gender equality in nutrition program requires taking into consideration the social, economic and biological differences between men and women and addressing the inequalities which are barriers to good nutrition.

Gender Sensitivity

Gender sensitivity is being aware of the differences between women's and men's needs, roles, responsibilities and constraints and seeking out opportunities and mechanisms to include and actively involve women as well as men in all activities. It requires redressing the existing gender inequalities by addressing gender norms, roles and access to resources as necessary to reach the project goal.

Gender roles and the division of labor in the household

The biological differences between men and women do not normally change; people are either male or female. However, the characteristics they are perceived to have, and the roles and responsibilities assigned to them, differ among societies, cultures, and historical periods.

Gender roles are the activities ascribed to men and women on the basis of perceived differences. "Division of labor" is a term used in gender literature to mean the roles and tasks assigned to women and men on the basis of perceived gender characteristics and attributes, instead of ability and skills.

Women's triple roles

Women's triple role classifies the work done by women into reproductive, productive and community

management. .

1. **Productive roles**: Tasks which contribute to the economic welfare of the household through production of goods. Women's role as producers is usually undermined and undervalued.

2. **Reproductive roles:** Activities performed for reproduction and caring for the household, water and fuel/wood collection, child care, health care, washing, cleaning, etc.

3. **Community management or socio-cultural activities**: Activities primarily carried out by girls, boys, men and women to ensure the co-existence of themselves as well as their family in their social environment.

A key lesson is that many of the activities that consume women's time—cooking, childcare, cleaning—are not considered "work" because they do not involve earning an income. Women's time is therefore considered less valuable than men's because they may not earn cash. When women are involved in earning income for the family, they generally continue to have all the additional responsibilities within the home.

Women retain primary responsibilities for tasks carried out around the home (reproductive roles) and taking care for the children, care for the old & animals that seek special attention. (pregnant cow, newly born calves etc)

In pastoral communities, in addition to animal husbandry tasks, women are responsible for the time consuming tasks of child care, food preparation, and water & fuel collection.

Gender Analysis and its importance in project designing and implementation

Gender analysis is a process of collecting and analyzing sex disaggregated information in order to understand gender differences. Gender analysis explores gender differences in policies, programs and projects can identify and meet the different needs of men and women.

Gender analysis is a systematic effort to identify and understand the roles, needs, opportunities and life circumstances of men and women. Gender analysis is a systematic effort to identify and understand the roles, needs, opportunities and life circumstances of men and women, girls and boys in a changing socio economic context.

Conducting a gender analysis as part of the needs assessment helps to identify the gender gaps that need to be addressed. For example the initial need assessment might show that child nutrition is perceived in a given community as a sole responsibility of mothers. If a child is malnourished or

shorter than the normal the mother is labeled and blamed as "bad". Such mothers are always embarrassed to bring their children to services.

It establishes baseline data, disaggregated by sex as foundation for measurable gender equality target, gender sensitive indicators of achievements.

The most common issues gender analysis looks into are;

Activity Profile: it answers the question "who does what?" including gender, age, time spent and location of the activity.

Access and control Profile: This identifies the resources used to carry out the work identified in the activity profile, and access to and control over their use, by gender

Analysis of factors and trends: which charts factors that influence gender differences in the above two profiles;

Program Cycle analysis: which examines a project or intervention in light of gender-disaggregated information (what gender circumstances are needed for project)

Men and women members of households have varying degree of claims and decision making power on assets and benefits. Women have lesser access to and control over resources than men in a given HHs. Small animals; home garden, poultry and small amount of cash are those resources over which women have relative decision powers in the households.

Table 1: Activity Profile

	Women	Men	Boys	Girls
Productive work				
1. Agriculture work (ploughing fields, hoeing, harvesting, transporting, etc.) 2. Livestock production (herding, forage preparation, feeding/watering cattle, health care, cleaning their pens, etc.) 3. Other activities (daily work, regular paid work, income generating activities, etc.)				
Reproductive work (activities carried out to maintain the family/household)				
1. Fetching water 2. Fetching fuel wood, preparing cow dung for fuel 3. Food preparation (processing, pounding, grinding, cooking,				

growing vegetables, serving, etc.) 4. Child care (feeding, bathing, health care, schooling, socialization, etc.) 5. Cleaning and repair (HH cleaning, washing clothes, compound cleaning) 6. Health care (caring for the sick, etc.)				
Community management activities				
1. Celebrations and ceremonies 2. Community meetings 3. Collective agricultural activities 4. Project activities				

What is gender Integration?

Gender integration involves identifying and then addressing gender differences and inequalities during program and project design, implementation, monitoring, and evaluation and attempting to compensate for gender based inequalities. Since the roles and relations of power between men and women affect how an activity is implemented, it is essential that project and activity planners address these issues on an ongoing basis. *For example, when a project conducts a gender analysis and incorporates the results into its objectives, work plan and M&E plan, it is undertaking a gender integration process*.

Gender integration is the process of promoting gender equality by making the consideration of women's and men's lived experience an integral part of our work. Its aim is to ensure that women and men benefit equally and inequality is not perpetuated.

Gender integration is required at all levels and stages of our work, including decision-making, policy, and program development. It is not meant to replace or exclude other types of analysis. Rather, it aims to ensure that gender factors are an integral part of all processes, not just an afterthought.

In some instances, gender may be integral to the issue being considered, and may play an important role in determining next step. In other cases, gender may be less significant to the outcome,

constituting one of several factors to be weighed. While gender implications may not be obvious at first, we must remain alert to their potential relevance in all cases.

The following are some tips in identifying ways to integrate gender concerns in health & nutrition interventions

- Incorporate gender analysis into regular nutrition activities. Collect information on how men and women are affected and address their needs and constraints in relation to nutrition.
- Involve and empower both men and women equally through nutrition education and SBCC. Focusing on women only, as victims, may instigate negative outcomes, such as inciting jealousy among men; turning men away from nutrition issues and actions resulting in the stigmatization of nutrition activities as "women's business."
- Acknowledge and promote the role of men in improving nutrition for their families. Engage men as partners, as care givers and as agents of positive change.
- Consult and include men and women in community meetings, demonstrations at the field level and monitoring & evaluation of nutrition interventions.
- Educate men and women on good fatherhood and motherhood practices, breastfeeding, complementary feeding and other nutrition matters.
- Incorporate gender awareness as part of the community awareness sessions and campaigns on health and nutrition matters.
- Conduct routine assessments and client exit interviews at facilities to assess the friendliness of services to mothers and children.
- Employ a gender perspective in the training of health workers in order to appropriately respond to the distinct health needs of men and women.

Session 8: Overview on Water, Sanitation and Hygiene (WASH) actions under nutrition programs

Learning objectives
1) **Discuss links between WASH and under-nutrition**
2) **Discuss the importance of hand washing at critical times and**
3) **Discuss how to manage household water treatment and safe storage**
4) **Describe importance of managing human excrement**
5) **Describe food hygiene and safety method**
6) **Discuss importance of cleaning child environment**

8. 1 Link between WASH and undernutriton

Key information

- The impact of improved drinking water, sanitation, and hygiene (WASH) on nutrition program is well documented.
- Improved WASH services in nutrition intervention has considerable effect on effectiveness and efficiency of program out puts
- Improved WASH services have greater impact on reduction of diarrheal incidence which is the major cause for illnesses and death among children age below two years.
- Diarrhoea and intestinal parasites affects the normal functioning of intestine & decrease absorption of nutrients which leads to diversion of calories away from the child growth and enhances stunting among the children.
- Environmental enteropathy (EE)- the chronic, subclinical disorder of the small intestine also contributing to malnutrition in children and results in inflammation in the gut and decreases absorption capacity of the intestine.

8.2 The links between WASH and under-nutrition

Direct links:

- The World Health Organization (WHO) estimates that 50% of malnutrition is associated with repeated diarrhoea or intestinal worm infections as a result of unsafe water, inadequate sanitation or insufficient hygiene[4].
- Diarrhoea is globally the leading cause of death and it is largely related to a lack of improved water supply, sanitation and hygiene[5].
- A constant presence and exposure to diarrheal diseases loss of macro and micronutrients which ends in under-nutrition.
- Globally, diarrhoea is the second leading cause of death in children under the age of five and it is mainly caused by ingesting contaminated foods or drinks and by direct person-to-person contact
- Hand washing alone contributes around 44% reduction to diarrhoea reduction[6]
- Pneumonia also has a direct link with poor hygienic practices and indoor air pollution.
- Household water treatment has contributed around 39 % reduction to diarrhoeal diseases.
- Parasitic infections, such as soil-transmitted helminthes (worms), caused by a lack of sanitation and hygiene, infect around 2 billion people globally, while an estimated 4.5 billion people are at risk of infection[7].
- Such infections can lead to anaemia and reduced physical and cognitive development.

Indirect links:

- problem with access to improved water supply system force mothers and children to fetch water from distant water source and so has impact on daily livelihood of the family
- Traveling distance to fetch water will also impact on poor educational performance of children
- Cost incurred to treatment of the illness can cost the family members and create economic burden to families

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[4] World Health Organization (2008c) Safer water, better health: Costs, benefits and sustainability of interventions to protect and promote health. Available at:http://whqlibdoc.who.int/publications/2008/9789241596435_eng.pdf

[5] Liu L, Johnson H L, Cousens S, Perin J, Scott S, Lawn J E, Rudan I, Prof Campbell H, Cibulskis R, Li M, Mathers C and Prof Black R E for the Child Health Epidemiology Reference Group of the World Health Organization and UNICEF (2012) Global, regional, and national causes of child mortality: An updated systematic analysis for 2010 with time trends since 2000. The Lancet [online], 11 May 2012, doi:10.1016/S0140-6736(12)60560-1

[6] Curtis, V. and S. Cairncross, (2003) "Effect of washing hands with soap on diarrhea risk in the community: a systematic review." Lancet 3: 275-281.

[7] Ziegelbauer K, Speich B, Ma¨usezahl D, Bos R, Keiser J et al (2012) Effect of sanitation on soil transmitted helminthic infection: Systematic review and meta-analysis, PLoS Med, vol 9, no 1, e1001162, doi: 10.1371/journal.pmed.1001162

8.3 Importance of hand washing at critical times

Learning objective 2. Discuss the importance of hand washing at critical times and demonstrate the appropriate hand washing steps

Hand washing demonstrations

preparation of a leaking container for hand washing demonstrations

- Get a 5 liter jerican and make a hole using a nail on the lower corner of the jerican.
- Fill the 5 liter jerican with water and hang it to some appropriate place eg window, tree etc. have the nail in place to stop the water from spilling out. Nail or piece of stick acts as a valve.
- Explain to the participants that the importance of using a leaking container is to save water- especially among the community members who have limited access to water .

Note: if the water is less in the container, open the lid to increase the pressure.

Proper hand washing steps

To know the methods for washing hands is very important because the soap alone is not enough to kill pathogenic organisms. It is the combination of soap, rubbing, rinsing and drying that gets rid of these organisms. Do not wash your hands with water only, but also with soap or an abrasive substance (ash).

The six steps of hand washing

Step 1. Wet hands with running water
Step 2. Apply soap
Step 3. Rub your hands vigorously to produce foam. Do not forget to rub the backs of hands, between fingers, under fingernails and wrists.
Step 4. Do not forget to clean nails
Step 5. Rinse away all soap
Step 6. Dry hands completely

Figure 2: proper hand washing steps

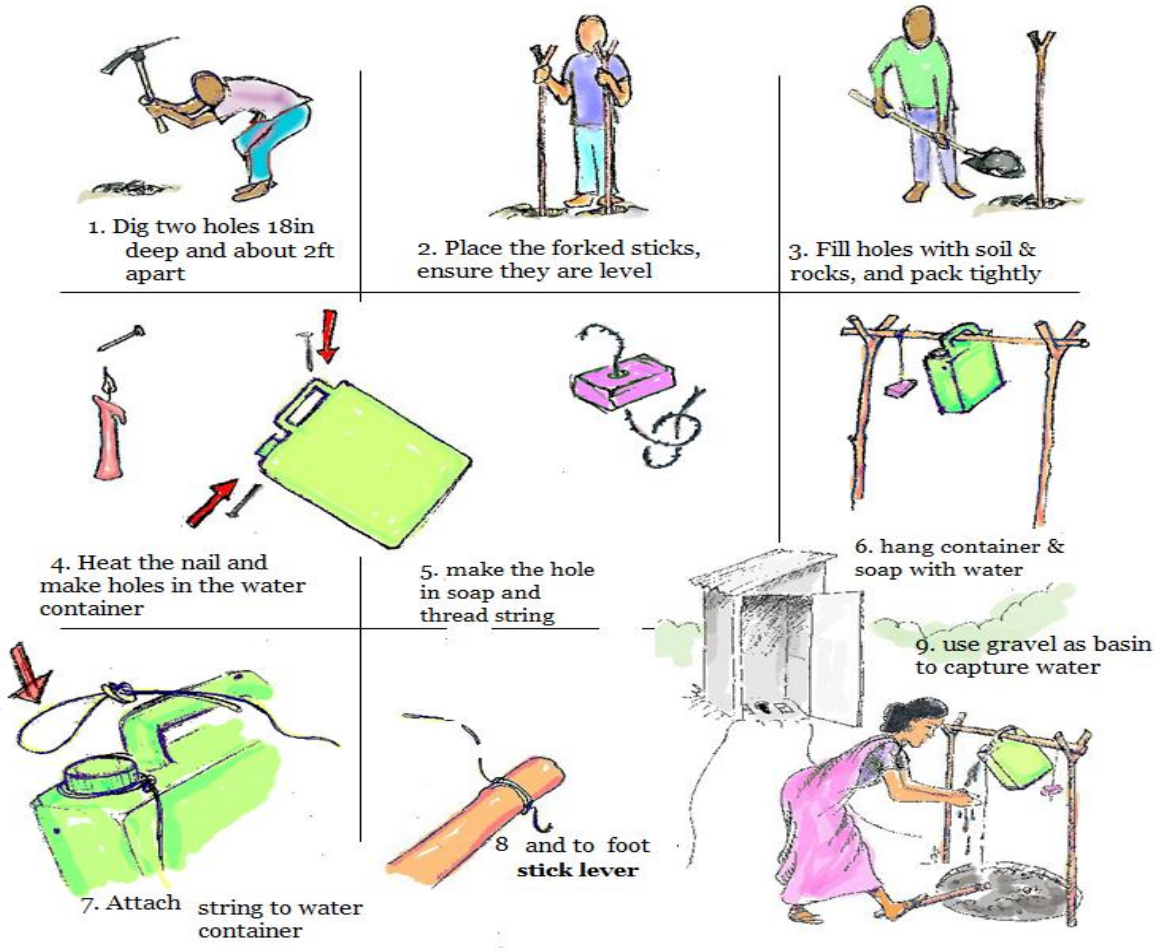
Key information

Critical times of washing hands

It is very important washing hand with water and soap or with other substitute items:

- ✓ Before eating and preparing food
- ✓ Before breastfeeding and feeding the children
- ✓ After defecation
- ✓ After cleaning the faeces of a child
- ✓ After taking care of someone with diarrhea
- ✓ After handling animals

Figure2, How to install typical Tippy Tap



key messages

- ✓ Hand washing with soap and safe water is one of the most effective ways to prevent and reduce diarrhoea among children.
- ✓ It is highly recommended washing hand at all critical times
- ✓ It is important following proper hand washing step as pouring water alone cannot help in preventing diseases.

8.4 Household Water Treatment and Safe Storage

Learning objective 3. Discuss how water gets contaminated and manage household water treatment and safe storage at household.

Key information

Importance of household water treatment and safe storage(HWTS)

- Treatment and safe storage of drinking water in the household have been shown to reduce the risk of diarrheal disease by 30–40 percent[8].
- The most promising and accessible of the technologies for household water treatment are filtration with ceramic/membrane filters, chlorination with storage in an improved vessel, solar disinfection in clear bottles by the combined action of UV radiation and heat, thermal disinfection (pasteurization) in opaque vessels with sunlight from solar cookers or reflectors and combination systems employing chemical coagulation-
- Research and implementation experience suggest that HWTS dramatically improves microbiological water quality; can significantly reduce diarrhoeal disease if used correctly and consistently by a vulnerable population; is highly cost-effective; and can be quickly implemented and taken up by vulnerable populations.
- HWTS can contribute to the MDG water target while advancing other health and development goals.
- HWTS should be targeted to the most vulnerable populations, including those with underdeveloped or impaired immune systems—children under 5, the elderly and people living with HIV/AIDS; displaced by war and conflicts; and high exposure to contaminated water—families relying on surface or unprotected water supplies, including those living in remote rural areas and urban slums.
- HWTS is highly cost-effective compared to conventional water supply interventions.

How water gets contaminated:

[8] Clasen et al. 2006. Interventions to Improve Water Quality for Preventing Diarrhoea. (A Cochrane Review). In:The Cochrane Library, Issue 3, 2006. Oxford: Update Software.

Water may get contaminated during the following stages:

Water sources: piped water, boreholes and wells, underground tank, river etc

↓

Transportation: by rolling on the ground, on the carrier's back (mostly women), on the head, by donkey barrel(cart), by wheelbarrow etc

↓

Storage at home: in 20L jerry cans, drums, Ensira and etc

↓

Drinking water: plastic jerry cans (including 20L jerry cans), glass

Water contamination can take place at any of the above stages in the water cycle.:

a. **Water sources**: if the source is not protected (animals can go in, people go into the water body with their feet / shoes), the catchment is not fenced or people are just defecating and that end up in the earth pan / tank / river

b. **During transportation**- the carrier can introduce diseases causing pathogens into the water. The jerry cans rolled on the ground all kind of dirties on the ground i.e sputum, faeces of both animals and human. And if its donkey cart, the barrel and its lid can be such good source of contamination

c. **At household storage level**, the cleanliness of the storage container, the lid and the method of drawing water from it are the potential source of water contamination

d. **At the drinking stage**-the cup or the glass used, the storage container, depending on whether it has a lid or not, and how wide is the lid will contribute a lot to water getting contaminated.

Key informations

General ways through which water gets contaminated includes the following:

- People defecating in or around the water source/ catchment of the water source.
- Urinating in or around the water source
- Dumping of rubbish in or around the water source
- Dirty water containers
- Sharing water with animals eg chickens and goats
- Constructing latrines close to the water source or sinking the pits upstream (a latrine should be 30 fts from the homestead and at least 100 fts from the water point)
- Poor management of the water point
- Grazing animals near the water point
- Washing children (especially faeces on their bottoms), legs, dirty clothes at the water point

Household Water Treatment and safe storage

It is apparent that providing all houses with improved water supply system is impossible in the nation within few years. To this effect, it is must advocating on the need to practice household water treatment and safe storage. There are several method proved to be effective and mostly appropriate for our rural communities. Household water treatment can be managed through chemical uses (Water guard, Purr, Bishan Gari and other) while boiling water at 100 degree centigrade is also proven well. Using household water filters is also well acknowledged new approaches in the nation. Let us see each one- by-one as follows.

1. ***Boiling:*** It related to physical removal of contaminant using high heat. It is highly cheap but difficult to practice on daily base as it needs time and fire wood to do so.

2. ***Chlorination:*** This is household water treatment method using chemical (chlorine products) like water guard, purr , Aqua tab and Bishan Gari and it is well proved approach. Water Guard, Purr Aqua tab and Bishan Gari are now available at market and easy to use at all level.

   Water Guard (Wuha Agar): add one tea spoon to treat 20 litters of water
   purr: add one packet to treat 10 litters of water
   Aqua Tab: add one tablet to treat 20 litter water

   -

   Bishan Gari: treats turbid and clear water. Add one sachet to treat 20 litters of water

3. ***Filtration using different types of filters:*** This is related to treating water using physical filtration of water and highly effective and efficient as long as it used properly and with the right procedures.

   Figure shows one of the filters

Figure 3: sawyer PointONE on imported bucket

Figure 4 Sawyer Point One Filter with local buckets

Water Storage Methods:

1. Store treated water in an appropriate vessel preferably with a narrow neck and a tap.

8.4 Safe disposal of human excreta in general and child feces in particular

Learning objective 4. **Discuss on safe disposal of human excrement**

Key information

key informations

- Safe disposal of feces reduces the risk of diarrheal disease by 30 percent or more[9].
- All household members has to use hygienic latrine.

[9] Fewtrell, L. et al. (2005). Water, sanitation, and hygiene interventions to reduce diarrhoea in less developed countries: a systematic review and meta-analysis. Lancet Infectious Diseases 5, 42-52; Arnold, B.F. et al. (2007). Treating water with chlorine at point-of-use to improve water quality and reduce child diarrhea in developing countries: a systematic review and meta-analysis." American Journal of Tropical Medicine and Hygiene 76(2), 354-364.

- Children and people with limited mobility should use adaptive technologies.
- Ensure a latrine meets minimum standards, including a cleanable platform, a cover over the pit, housing that provides privacy, and a hand washing station nearby (ideally located next to the latrine and/or cooking area).
- If a latrine is not available for individual HH use communal latrines or bury Maintain latrines properly by clearing the path to the latrine, removing obstacles such as stones and branches, and filling holes in the path to facilitate easier access.
- The platform, seat, walls, or other surface of the latrine should be feces free.
- All anal cleansing materials should be placed in the latrine itself.
- A scoop of lime or ash in the latrine after defecation can reduce odors and deter flies.

Resource material: 1
How diarrhoea is spread and means to prevent it:

Diarrhoeal infections can be spread through:

- soil
- oral- fecal root
- Contaminated food
- Contaminated water
-

Different ways to prevent diarrhoea:

- Drinking Safe treated Water
- Hand washing at critical times (after using latrine and before eating/handling food items)preferably with soap and safe water
- Disposing of excreta safely (Latrine use or bury excreta)
- Hygienic preparation and consumption of food

How to block the contamination route of diarrhoea

The F- diagram: Source the PHAST hand book

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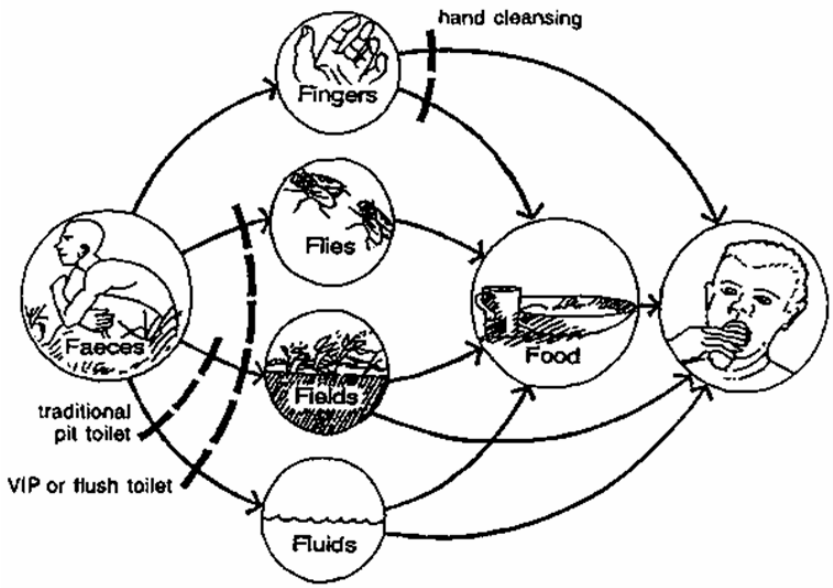


Figure 5 F-Diagram

Handling of human excrement (Adult and child fecal materials).

Ways to manage human fecal matter includes:

- Use of a latrines, toilets etc
- Where, the are no latrines, burying the fecal matter under the soil (referred to as the cat method)

1.

Always Remember!

- ✓ When there are no latrines, people may defecate in a hole far (cat method) away from the house and from the water supply (village, well, river, spring or pond). Cover the hole with earth after defecating.
- ✓ Always wash hands with soap and water after defecating and changing baby diapers.
- ✓ Diarrhoea is generally caused by eating food or drinking water that is contaminated with human faeces
- ✓ Babies and infants may suffer from diarrhoea after being fed by someone with dirty hands or having put dirty objects into their mouths.
- ✓ The F diagram hand out shows the ways that diarrhoea germs mainly reach people including via fingers, flies, fields and fluids, food or directly into the mouth.

Key messages

- ✓ Human excreta are highly contagious and should be managing in safer manner.
- ✓ Having hand washing facility near latrine can do a lot in mitigating excreta related diseases.
- ✓ Having improved latrine motivate benefices to properly use and maintain the facilities

8.5 Food Hygiene and Safety

Learning objective 5. Describe food hygiene and safety method

Key information

Food sources that easily get contaminated and cause food poisoning.

All foods can get contaminated. But foods that have higher risk of contamination and spreading disease include the following: Red meats, Poultry, Eggs, Raw fish, Raw vegetables and

At what stages of food consumption does food get contaminated?

During preparation- poorly washed raw foods and vegetables, cross contamination during preparation, use of dirty contaminated water to wash fruits and vegetables that are eaten raw, dirty hands, flies resting on fruits and vegetables that don't require cooking.

During eating- dirty hands, role of flies (that are contaminated by human feaces), use of dirty and contaminated utensils etc

During storage- when food is left uncovered it can exposed to various external contaminates like flies and rodents and consequently become poison to health.

How to block contamination route of foods;

- Wash hands during critical times
- proper human and animal excreta disposal.
- .
- Wear protective devices or avoid preparing food if your hands have any cuts or sores.
- Avoid cross-contaminating food items (separate meat, poultry, and seafood from other foods and always wash your hands, utensils, and cutting boards after they come into contact with these products).
- Leftovers must be reheated to a boil before eating.

General Rules to Follow

1. If you have any communicable disease (e.g., a cough, cold, sore throat) or infection, DO NOT handles food. Reschedule the food demonstration or have a colleague conduct it.
2. Keep beards and moustaches trimmed and cleaned. Ideally, be clean-shaven.
3. Wash hands and exposed parts of arms before the demonstration and as often as necessary(at all critical times)After eating or drinking
4. Keep hands away from the face, eyes, hair, and arms.
5. Keep fingernails clean and short.
6. Cover cuts and sores with clean bandages.

Food Handling and Preparation

There are two major sanitation problems when handling and preparing food:

a. Cross contamination—the transfer of bacteria from one source to another. Bacteria transfer may occur from food to food, from equipment to food or from work surface to food.

b. Bacterial growth—the multiplication of bacteria. This is most likely to occur when working in the *Danger Zone* (between 41° and 140°F); most fresh foods fall into this temperature range.

General Rules to follow:

a. Handle foods as little as possible.

b. Keep equipment, work tables, and stations clean and sanitary at all times.
c. Clean as you go. Do not wait until the end of the day to clean everything at once.
d. After handling raw poultry, meat, fish, or eggs, immediately clean and sanitize cutting surfaces and equipment.
e. Wash raw vegetables and fruits thoroughly. Use a brush and/or water bath.
f. Freeze or refrigerate perishables, prepared food, and leftovers within two hours.
g. Keep foods covered.
h. Do not mix leftover food with freshly prepared food.
i. Boil leftover gravies, soups, and sauces before serving.

Equipment Cleaning and Sanitizing

While **cleaning** means the removal of visible soil, **sanitizing** means the removal of disease-causing bacteria. Bacteria are destroyed in two ways—by using heat or by using chemicals.

Manual Dishwashing

1. **Scrape and pre-rinse**. This step keeps the washing water clean longer.
2. **Wash**. This removes all soil and grease. Use warm water (110°F; 43°C) and a cleaning agent. Scrub equipment well with a brush. Replace cleaning agent solution when water is unclear or suds have disappeared.
3. **Rinse**. The purpose of rinsing is to remove all soap from the equipment. Use clean, warm water (110°F; 43°C), and change the water several times. Use running water to rinse equipment when a 3-compartment sink is not available.
4. **Sanitize**. Place equipment in a rack and immerse it in hot water (171°F; 77°C) for 30 seconds. Sanitizing can also be completed with disinfectants instead of heat. If disinfectant chemicals are used it is important to follow the instructions on the manufacturer's label. Example sanitizing solution: mix 3 tablespoons of liquid bleach into 1 gallon of water.

key messages

- ✓ Food hygiene and safety is mandatory for prevention of food poisoning and contamination.
- ✓ children should be feed with fresh food
- ✓ Hand washing before preparation and during feeding child is mandatory

8.6 Keeping child Environment Clean and Safe

Learning objective 6. Discuss importance of clean environment for child and the need to promote child friendly floor mat among children blow age of two years

Key information

- It is natural for children to play on the ground and put all Martials around to their mouth and exposed to contaminants available at their playing environment.
- Based on ENGINE formative research, at WASH focused districts of Oromia, Amahara, SNNPR and Tigray regions, almost all households have no appropriate, child friendly and clean mats[10].
- To this effect, it is highly important promoting child friendly and clean mats among households with child age below two year.
- It is important keeping child environment through good housekeeping and frequent cleaning of the living and working environment at households.

Figure **6** Child friendly floor mat used during willingness to pay assessment

key messages

- ✓ Children are naturally interested to take things in the mouth and learn about their environment
- ✓ Clean environment for child is mandatory to keep the child clean and avoid contamination
- ✓ It is the responsibility of child care provider to clean the child environment and keep the child away from unclean environment

[10] Save the children International (USAID/ENGINE) in collaboration with Manoff Group. WATER, HYGIENE AND SANITATION (WASH) IN RURAL HOUSEHOLDS IN AMHARA, OROMIA, SNNP, AND TIGRAY. Addis Ababa, June, 2014

Questions to be used during pre and post testing activities.

Ser. No	issues to be asked	Yes	No	Don't know
1	washing hands with water only is adequate way to prevents diarrhoea diseases			
2	Household water treatment and safe storage is the key in prevention and control of diarrheal diseases			
3	proper food handling right from harvesting to table of consumption is impossible as food safety chain is beyond the control of individual consumer			
4				
5	Water that is clear is not always safe to drink and should be treated			

Session 9: Supervision and Mentoring

9.1 Supervision

Introduction

Good supervision can increase the competence and satisfaction of providers, which improves the performance of the facility, which in turn can increase the well-being and satisfaction of clients. One of the primary responsibilities of a program supervisor in a health or agriculture sector is to improve the performance of people. A supervisor of a nutrition program works to make sure that people in need of nutrition guidance receive good-quality services from those who provide them.

The performance of a program can be improved by giving due attention to each element of the program and through involving the client and community in the planning and identification of gaps in the sector. It is, however, equally important to obtain feedback, comments and suggestions from the clients and community, to provide tools to the staff for self and peer supervision, to provide standards and guidelines to supervisors, and to build the capacity of the supervisor in setting and communicating standards, monitoring performance according to the standards, building teams and strengthening communication skills.

Learning objectives

1. Describe the concept and purpose of supervision
2. Planning and conducting a supervision

What is Supervision?

Supervision of a program or a service is defined as a process of guiding, helping, training and encouraging staff to improve their performance in order to provide high-quality services. Supervision can be conducted by someone at the facility (internal supervisor) or by someone outside the facility who makes periodic supervision visits (external supervisor).

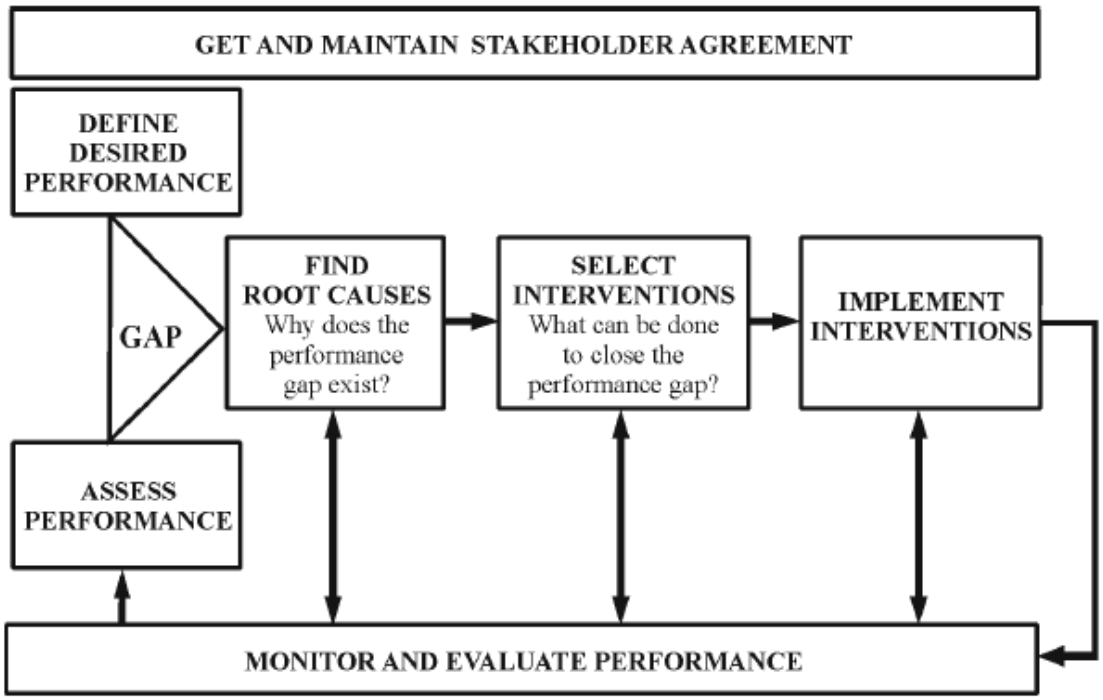
Supervision to improve performance and quality of services: Performance improvement process/steps.

Traditional approaches to supervision emphasize 'inspecting' facilities and 'controlling' individual performance. This type of supervision causes negative feelings and rarely results in improved performance. In contrast, supervision for improvement of performance and quality of services focuses on:

- the goal of providing high-quality services;
- the use of a process of continuous improvement of staff performance and quality of services; and
- a style of encouraging and supportive interaction with all staff and other stakeholders.

The process that supervisors use to identify a performance gap and its causes and to create solutions for closing the gap is called **performance improvement (PI)**; this process is illustrated in **Figure 1** below.

Figure 1: The performance improvement process



The performance improvement process has the following steps:

1. **Get and maintain stakeholder participation:** This step helps to have a common understanding of the desired performance, assess the current performance and identify gaps through active participation of staff, community members and representatives from different service delivery levels.
2. **Define desired performance:** Desired performance needs to be based on goals set by the stakeholders and take into account the resources at the facility (staff, budget, supplies, etc.). Standards are helpful to set desired performance (e.g., nutrition service standard).
3. **Assess current performance:** This can be conducted on an ongoing basis through self-assessments, obtaining feedback from clients and observation by staff or external supervisors.
4. **Identify performance gaps and their causes:** Performance gaps are the difference between the current and desired performances. The supervisor/staff needs to identify possible causes in order to obtain workable solutions.
5. **Select and implement steps to improve performance gaps:** Once performance gaps are identified, the supervisor and/or staff needs to develop and implement ways to improve the performance. Proposed steps should be achievable considering the capacity of the facility.
6. **Monitor and evaluate performance:** While implementing the steps to improve performance, it is important that the supervisor/staff determines whether or not performance has been improved.

Planning and conducting a supervision visit

Planning a supervision visit: It is important that any supervision is well planned. If not, time will be wasted and very little will be accomplished. To ensure a well-planned supervision visit, a supervisor or team of supervisors should consider the following:

- ***Set objectives for your supervision visit***: Setting objectives and making sure that each team has a similar understanding is important to guide the whole supervision process.
- ***Decide on which activities you will focus***: Based on the supervision objective, you and your team need to know exactly what you will do during your visit to the facility or community to make effective use your time and that of the staff you are visiting.
- ***Review the performance and quality standards and indicators:*** If there are previous standards, you need to review them to ensure that your assessment is using those standards.
- ***Review and prepare supervision instruments that you will use:*** Supervision tools (e.g., Supervision checklist) are important to guide your visit. You need to have an appropriate, updated version of the tools.
- ***Make administrative preparations:*** To have a productive trip, administrative arrangements are necessary which includes gathering documents, notifying the facility or site to be visited, logistical arrangements, etc.

Conducting a supervision visit: Conducting a supervision visit is the most important part of a supervisor's job. During the visit, the supervisor demonstrates technical as well as communication and management skills. The supervisor also transfers knowledge and skills and facilitates problem solving by the team. Specific activities to be conducted include:

- *Holding a meeting with site staff* to discuss the purpose and process of the supervision;
- *Observing service provision and client-provider interaction;*
- *Examining client records and facility statistics;*
- *Observing work conditions* such as physical environment, equipment, communication materials, etc.;
- *Having discussions with clients/service users;*
- *Helping staff conduct self-assessments*: Encouraging the staff of the facility or the site being visited to conduct an ongoing self-assessment helps them to monitor their progress and take appropriate measures in time to improve their performance;
- *Debriefing the staff before departure*: Debriefing is helpful to report candid observations (both achievements and areas which need improvement) and to ensure that the findings are valid and commonly agreed upon by the staff. It will also help the staff to start taking immediate measures rather than waiting for an official report;
- *Establishing a follow-up plan*: The findings of the supervision should include clear action points as a follow-up to improve the gaps observed during the supervision;
- *Writing and submitting a report:* This needs to be done on time and should be addressed to all concerned;
- *Following-up on recommended actions*: Writing and submitting a report is not the end of supervision visit. There needs to be a way to monitor the implementation of agreed actions. The findings of the follow-up should be used as a point of reference for the next supervision visit.

9.2 Mentoring

Introduction

Mentoring is a challenging task that requires flexibility, skill in coordinating different stakeholders, excellent communication and relationship-building skills, the ability to cope with rapid change of direction, in addition to possessing up-to-date technical knowledge and teaching skills.

Learning objectives

1. Explain the concept of mentoring.
2. Describe effective mentoring and demonstrate mentoring skills.

What is Mentoring?

Mentoring is a process in which an experienced individual helps another person to develop his or her goals and skills through a series of time-limited, one-on-one conversations and other learning activities.[11]

A mentor's ultimate goal is to help each team member to be the best they can be and do the best job possible to help maximize performance and quality of services.

Effective mentoring skills

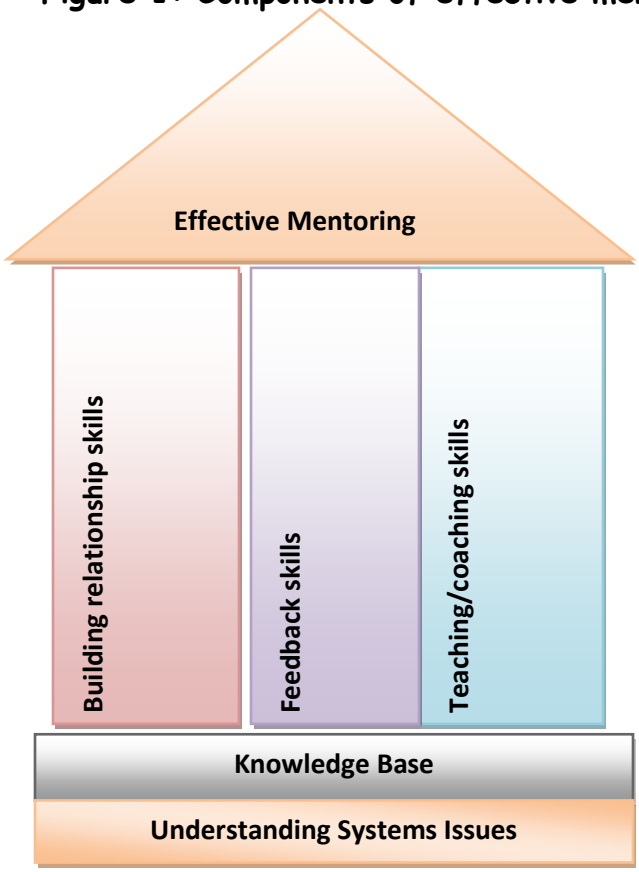
For effective mentoring, a mentor needs to know and practice five important components. The first two components are critical foundations that a mentor needs to start his/her mentorship task. The other three components are important skills that the mentor needs to apply/practice while mentoring health workers or staff.

The five components of effective mentoring (see Figure 1 below) are:

1. Knowledge base
2. Understanding systems issues
3. Building relationship skills
4. Feedback skills
5. Teaching/coaching skills

[11] Center for Health Leadership and Practice (2003) Mentoring Guide: A Guide for Mentors. Oakland, CA

Figure 1: Components of effective mentoring



9.2.1 Component-1: Knowledge Base

It is crucial that the mentor have solid and up-to-date technical knowledge of both clinical and preventive nutrition. As hospital, woreda or health center staff, you may work as a mentor of health workers or health extension workers. To this end, you need to have a higher level of technical knowledge of nutrition related issues in order to help improve the health worker's skills which are necessary to provide quality nutrition services.

It is important to note that mentorship is also a process where both the mentor and mentee learn experiences from one another; therefore a mentor needs to be open minded to learn from his/her mentee as well.

To increase his/her knowledge of nutrition related issues, a mentor may use different methods (e.g., reading relevant books and reference materials, asking experts and exploring learning opportunities such as trainings, workshops, etc.).

9.2.2 Component-2: Understanding Systems Issues

Mentoring is not only about coaching/teaching a health worker to improve her/his skills, but also about understanding systems issues and providing the required support to strengthen the system.

Examples of systems issues include: long client queues as a result of staff shortages or other reasons; poor recording systems; shortage of supplies and equipment; poor management or leadership in the facility.

Before supporting the health worker to address such system related issues, it is important to understand the existence of such problems. As a mentor, you may already know about such problems from previous reports, review meetings or from the mentee/health worker.
Examples of supporting a mentee to address some systems issues are listed below.

- Shortage of nutrition related supplies and equipment: Mentor may facilitate vehicle or other means to bring supplies from the woreda or region; mentor may bring communication materials that are available at woreda or region or in an NGO; mentor may initiate a discussion on exploring gaps in the supply chain system with possible solutions.
- Long patient queue: Mentor may sit side-by-side with mentee and assist with the work (e.g., mentee can counsel the mother and mentor can help with recording the data on a client card).
- Poor client recording systems: Mentor can create a documentation checklist to help the mentees remember to record the information.

9.2.3 Component-3: Building Relationship Skills

The remaining three components of effective mentoring including this one are about mentoring skills. Mentoring skills are the cornerstones to improve the performance and skills of a mentee in a mentorship program.

Building relationships with mentees helps the mentor to build trust and mutual respect with the mentee(s) to avoid barriers or discomfort during the mentorship process. The mentee's social and cultural environment is an important first step in the mentorship process.

At the beginning, you may try to examine cultural differences with your mentee(s) and this could help as a start-up to building your relationship. You can conduct this using the Worksheet 7.1 (see below).

Worksheet 9.1: Examining Cultural Differences

Instructions:

- Fill out the chart below using yourself as the mentor. Then fill out the mentee column based on what you know about the people you will be mentoring or you have mentored.
- Pair up to discuss your charts and answer the questions below the chart. You will present your answers to the large group once you are finished.

	You, the mentor	**Your mentee(s)**
Gender		
Race/ethnicity		
National/regional origin		
Language		
Age		
Profession		
Level of education		
Religion		
Other (anything you want to mention)		

Questions

1. How might the differences between your column and the mentee column affect your mentee's attitude:
   - Upon meeting you?
   - As you begin interacting with him/her?
   - As you begin providing feedback about his/her performance?
2. How might these differences affect your attitude?
   - Before meeting your mentee?
   - Upon meeting him/her?
   - As you start building a relationship with him/her?
3. When confronted with situations that are not immediately comfortable, what are some steps that you, as a mentor, can take in order to overcome the discomfort/mistrust?
4. If your columns are more similar than different, what implications might that have for your mentor/mentee relationship?

Key skills to build good working relationships with mentee

Key skills that help a mentor build good working relationships with his/her mentee(s):

1. Shaking hands
2. Introducing yourself
3. Using the same language as the mentee(s)
4. Showing patience; don't interrupt
5. Making appropriate eye contact
6. Not attending to other tasks while meeting with mentee
7. Using gestures that show you are interested and engaged ('uh-huh', 'nodding', 'yes'.)
8. Using affirming statements: Affirming statements are positive words that acknowledge, support and encourage someone's strengths (e.g., "*I like the way that you spoke to the patient and his family*"; "*You handled that challenging situation very well*".)

9.2.4 Component-4: Feedback Skills

Understanding feedback

In our daily routine, we may provide feedback to others and receive feedback from supervisors, friends, experts, etc. Giving feedback is an important part of the mentorship process. Mentors convey knowledge and skills to mentees through feedback. For feedback to be effective, however, it must be offered in a way that will be received by the mentee.

There are many different ways to communicate and our choice of words and how we say something can have a huge impact on whether or not the interaction is positive and effective. This is especially true when giving feedback.

Feedback is providing comments in the form of opinions or reactions to something.

- The purpose of feedback could be to initiate and improve communication; to evaluate or modify a process or conduct; to enable improvements to be made; or to provide useful information for future decisions.
- If a mentor is unable to give feedback effectively, and/or the mentee is unable to receive constructive feedback, not much will be accomplished.
- Note that feedback can be positive or negative but the sole purpose is to improve performance, not punish poor performance.
- *How we give feedback, what we say, how we say it,* and *when we say it* is critical to whether the feedback is useful and achieves the intended effect.

Basic principles of giving feedback

Feedback is integral to adult learning and is a vital component of effective mentoring. Feedback should include both "positive" and "how to improve" commentary; be descriptive, objective and non-judgmental; and focus on the individual's actions.

Handout 9.1: Basic Principles of Giving Feedback

1. Ask permission or explain that you are giving feedback. Examples:
   - "Can I give you some feedback on that follow-up patient visit?"
   - "I'd like to provide some feedback on what I observed during the visit today."
2. Give feedback in a "feedback sandwich."
   - Start with a positive observation ("It was good that you…")
   - Provide a constructive critical observation or suggestion for improvement.
   - Finish with a second positive observation or summary statement.
3. Describe what you observed and be specific. State facts, not opinions, interpretations or judgments.
4. Feedback should address what a person did, not your interpretation of his or her motivation or reason for it.
   - Action: "You skipped several sections of the counseling script."
   - Interpretation: "You skipped several sections of the counseling script. I know you wanted to finish quickly because it's almost lunch time, but…"
5. Don't exaggerate. Avoid terms such as "you always" or "you never."
6. Don't be judgmental or use labels. Avoid words like "lazy," "careless," or "forgetful."
7. When making suggestions for improvement, use statements like, "You may want to consider…" or "Another option is…"
8. Don't wait too long to give feedback. The closer the feedback is to the actual event, the more likely the mentee will remember the teaching point.
9. Certain feedback requires more immediate timing; for example, if you see that the HEW is doing something incorrectly or omitting a very important step during the visit.
10. If you provide feedback during a patient encounter:
    - Do not alarm the HEW or patient. Put them both at ease.
    - Be very calm and patient as you explain your recommendation.

9.2.5 Component-5: Teaching/Coaching Skills

Teaching/coaching moments

Teaching/coaching moments are opportunities to share information, demonstrate a technique to a mentee or enhance the knowledge and skills of the mentee. All contact points for nutrition can be used as opportunities to teach/coach a mentee. This can be at an antenatal care visit, in the delivery room, during immunizations at a health center or health post, at child consultations (sick and well baby clinic), during outpatient therapeutic program (OTP), during postnatal care services, during visits to the health development army, at outreach programs, etc.

Teaching/coaching can be provided while a client is in the room, following the client's visit, following community group discussions, or it can be planned for future visits depending on the amount of time needed.

Teaching/coaching techniques

Different teaching/coaching techniques

Side-by-side teaching: This technique involves working alongside the mentee and providing information on a specific topic.

Demonstration/Role-play: In this technique a mentor demonstrates a specific skill to the mentee and helps the mentee to acquire the skill.

Case studies: A mentor may present specific case studies and challenge the mentee to address questions related to the case study (e.g., a case study about a malnourished child who was not treated properly in a stabilization center).

Group discussions: This technique is helpful particularly when there are a number of mentees. In this case, the mentor may raise issues for discussion and initiate a group learning and discussion to address the problems observed during the mentoring program.